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# ROYAL COMMISSION ON HEALTH SERVICES

ENGLISH VERSION

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VOLUME 42

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Mr. R.N. HALL, Q.C.

MEDICAL CONSULTANT:

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Prof. BERNARD BLANCHET

SECRETARY:

Mr. N. LAFRANCE



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ANGUS, STONEHOUSE & CO. LTD.  
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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearing held  
at Montreal, Province of Quebec,  
Thursday, April 12th, 1962.

COMMISSION MEMBERS:

Chief Justice EMMETT M. HALL -- Chairman

Miss ALICE GIRARD, R.N.

Dr. DAVID M. BALTZAN

Prof. O.J. FIRESTONE

Mr. M. WALLACE McCUTCHEON, Q.C. -- Acting Chairman

Dr. C.L. STRACHAN

Dr. ARTHUR F. VAN WART

COMMISSION COUNSEL:

Mr. R.N. HALL, Q.C.

MEDICAL CONSULTANT:

Dr. PIERRE JOBIN

DIRECTOR OF RESEARCH:

Prof. BERNARD BLISHEN

SECRETARY:

Mr. N. LAFRANCE







Montreal, Province of  
Quebec, Thursday, 12th  
April, 1962.

--- On commencing at 9.30 a.m.

THE ACTING CHAIRMAN: Gentlemen, if  
you will come to order. Before we call on the Dental  
Surgeons of the Province of Quebec, there is a written  
submission which we have received which I will ask the  
Secretary to read into the record.

THE SECRETARY: Mr. Chairman, I have a  
letter from the Jewish Immigrant Aid Services of Canada  
which is addressed to me with some points that I would  
like to place on the record of this Commission. It  
reads as follows:

"This is with reference to your letter  
of February 16th 1962. Originally we  
were planning to submit a brief to the  
Royal Commission on Health Services.  
However, we now feel that it may not be  
necessary.

As members of the Canadian Welfare  
Council we are identified with the  
brief which will be submitted by this  
organization. There is, however, one  
specific point which we would like to  
stress and bring to the attention of  
the Royal Commission. Perhaps this  
letter should go on the records of  
the Royal Commission pertaining to  
this aspect. Thus a separate brief  
may not be indicated which we feel







1 would save a great deal of valuable  
2 time for the Commission. The parti-  
3 cular question which we have in mind  
4 is as follows.

5 We feel that newcomers to Canada,  
6 with respect to certain health facili-  
7 ties, do not derive the same benefits  
8 as Canadian residents, especially  
9 during the initial stages of their  
10 arrival. We are not fully acquainted  
11 with the provisions in all Canadian  
12 provinces but we would like to cite  
13 as examples the Provinces of Quebec  
14 and Ontario which, by the way, are  
15 the major points of destination for  
16 newcomers.

17 In Ontario, for example, the hospital  
18 insurance scheme is compulsory with  
19 firms of 15 employees or over.

20 Employees working in smaller firms  
21 must assume responsibility for enrol-  
22 ment on their own. Many newcomers  
23 are not necessarily employed with  
24 larger firms and may, either because  
25 of ignorance or for other reasons,  
26 fail to enrol in the Hospital Insu-  
27 rance Plan. Should such a newcomer  
28 become hospitalized, the family will  
29 then be faced with the tremendous  
30 problem of hospitalization costs.





Moreover, even if an immigrant is aware of the hospitalization plan and enrolls soon after arrival, he cannot benefit from the insurance provision until three months of residence have elapsed. Of itself, the waiting period of three months is perhaps not too lengthy but should an immigrant take ill within this initial stage when he has so many other problems of adjustment, any hospitalization costs would be a very heavy burden.

With reference to Quebec the provisions regarding residence are the same. A person must reside in the province for at least three months before he becomes eligible.

As indicated above, we do not know what the situation is in other provinces but we feel that the matter should be explored and some formula devised to enable the newcomer to benefit from existing provisions.

Our concrete suggestion is that immigrants should be eligible for the provincial hospitalization and insurance provisions upon arrival in Canada and upon reaching their point of destination. It is exactly the







1 first few months which are crucial to  
2 any immigrant and such provision,  
3 if instituted, would certainly go a  
4 long way in alleviating a very serious  
5 potential burden.

6 We trust that the Royal Commission  
7 will explore and give consideration  
8 to the above problem.

9 Sincerely yours, J. Kage, National  
10 Executive Director."

11 THE ACTING CHAIRMAN: Thank you very  
12 much, Mr. Lafrance. The first submission this morning  
13 is from the College of Dental Surgeons of the Province  
14 of Quebec and I believe Dr. Langlois is making the  
15 submission. Dr. Langlois?

16 SUBMISSION OF THE COLLEGE OF DENTAL SURGEONS  
17 OF THE PROVINCE OF QUEBEC.

18 Appearances: Dr. R. Langlois  
19 Dr. H. Oliver  
20 Dr. G. Ratte  
21 Dr. R.M. LeBlanc  
22 Dr. L. Bernier  
23 Dr. D.B. Ward  
24 Dr. C. Baer  
25 Dr. G. Zimmerman  
26 Dr. G. Dundas

27 DR. LANGLOIS: Mr. Chairman and members  
28 of the Commission: I should like, before submitting the  
29 summary of our brief, to explain here that the College  
30 of Dental Surgeons in Quebec is the only administrative  
organization, the only legal organization from the  
dental standpoint in this province. It is the only  
authorized organization which is entitled to present  
the views of the dental corps in the Province of Quebec.



first few minutes which was devoted to  
any important and such a resolution  
in instigated, would certainly go a  
long way in alleviating a very serious

We trust that the Royal Commission  
will explore and give consideration  
to the above problem

Executive Director."

THE ACTING CHAIRMAN: Thank you very  
much, Mr. Lefebvre. The first submission this morning  
is from the College of Dental Surgeons of the Province  
of Quebec and I believe Mr. Langlois is making the

SEPARATION OF THE COLLEGE OF DENTAL SURGEONS

OF THE PROVINCE OF QUEBEC

- Dr. H. Oliver
- Dr. J. Harte
- Dr. R. M. de Biana
- Dr. J. L. Gauthier
- Dr. J. E. Gauthier
- Dr. G. Baer
- Dr. G. Poirier

... of our belief, to explain here that the College  
of Dental Surgeons in Quebec is the only authority  
of regulation, the only legal organization from the  
... of this province. It is the only  
... which is entitled to practice  
... of the dental corps in the Province of Quebec





1 All dentists in Quebec are members of  
2 the College of Dental Surgeons of the Province of Quebec  
3 and there are some 1,412 members. We will submit to  
4 you the views of the College of Dental Surgeons of the  
5 Province of Quebec.

6 In presenting these views, the College  
7 is mindful that any question concerning health is the  
8 responsibility of the Province and that any decision  
9 on it comes under the domain of the Province.

10 1. In its brief, the College of Dental  
11 Surgeons submits that:

- 12 a). Its members are able to meet the  
13 current demand for dental services;  
14 b) If all the factors capable of  
15 rapidly increasing this demand are  
16 not balanced by a proportional  
17 increase of practitioners, our profes-  
18 sion will not be able to meet its  
19 responsibilities.

20 2. This brief recommends urgent action  
21 to:

- 22 a). Stimulate the recruitment of  
23 dental students;  
24 b) Provide increased accommodation in  
25 our dental faculties or create  
26 additional ones;  
27 c) Encourage scientific research;  
28 d) Fluoridate drinking water.

29 3. This brief explains why the College  
30 is opposed to any compulsory State-run plan for dentistry.





1 It recommends that an assistance plan be applied to  
2 children who are under the auspices of the Department  
3 of Social Welfare and encourages voluntary group pre-  
4 payment plans covering dental services.

5 THE ACTING CHAIRMAN: Thank you, Dr.  
6 Langlois. Is there anything that any of the members  
7 would like to elaborate on or address themselves to  
8 before we turn to questioning?

9 DR. LANGLOIS: No, we have nothing  
10 special.

11 THE ACTING CHAIRMAN: Your body, I  
12 take it, is the licensing body for the province?

13 DR. LANGLOIS: Yes, sir.

14 THE ACTING CHAIRMAN: In order to  
15 practise dentistry in the Province of Quebec you must  
16 be a member of the College of Dental Surgeons?

17 DR. LANGLOIS: Yes.

18 THE ACTING CHAIRMAN: You establish  
19 the professional requirements and you discipline your  
20 members for non-professional conduct?

21 DR. LANGLOIS: Yes.

22 THE ACTING CHAIRMAN: Do you establish  
23 scales of fees?

24 DR. LANGLOIS: Yes.

25 THE ACTING CHAIRMAN: Dr. Strachan,  
26 have you some questions?

27 COMMISSIONER STRACHAN: Thank you, Mr.  
28 Chairman. You have stated that the current demand for  
29 dental services in Quebec is being met; what percentage  
30 of the population receive dental services in a year?







1 DR. LANGLOIS: In 1958 27.3% of the  
2 population received dental care in the Province of  
3 Quebec. Of this number around 50% of the treatment  
4 given was emergency treatment.

5 COMMISSIONER STRACHAN: 27.3% represents  
6 those getting regular attention, is that it?

7 DR. LANGLOIS: No, this includes both  
8 regular treatment and emergency treatment. I have the  
9 impression that this percentage of regular treatment is  
10 somewhat less than this figure of 27.3%.

11 COMMISSIONER STRACHAN: That is low in  
12 comparison to other parts of Canada; can you account  
13 for it?

14 DR. LANGLOIS: I believe that we can  
15 account for this situation by considering first the  
16 economic element. In the Province of Quebec the  
17 average salaries are lower, generally speaking, than  
18 in the other provinces. Secondly, the shortage of  
19 dental services and there is probably inadequate dental  
20 education in the Province of Quebec at the present time.

21 COMMISSIONER STRACHAN: Would rural  
22 areas account for that to a degree too?

23 DR. LANGLOIS: Yes, I think this is  
24 the main cause of the situation from the rural aspect.  
25 This is a considerable element in the Province of Quebec,  
26 more so than in the other provinces. Perhaps Dr. Bernier  
27 would comment.

28 DR. BERNIER: Of the total population  
29 of around 5,500,000 people we can calculate that about  
30 half the population consist of the rural inhabitants







1 where dental services are more difficult to obtain and  
2 this partially explains, I believe, the lesser incidence  
3 of dental care as compared with the other provinces.

4 COMMISSIONER STRACHAN: With reference  
5 to the rural population, have you anything in the way  
6 of travelling clinics that might take care of outlying  
7 areas?

8 DR. LE BLANC: At the present time  
9 we have a service which is carried out by the Red Cross  
10 and I think they have three or four travelling clinics.  
11 They go into certain remote areas and that is about all  
12 we have. This service operates only during the mild  
13 weather, during part of the year.

14 Of course, we also have a system of  
15 sanitary units composed of 73 dentists; seven of them  
16 work full-time and the remainder work on a part-time  
17 basis. These dentists cover the small areas mainly and  
18 they deal mostly with children. That is a governmental  
19 service.

20 These sanitary units have done a lot  
21 of good work because they have disseminated dental  
22 hygiene education amongst the public.

23 COMMISSIONER STRACHAN: Well, in the  
24 urban areas how do people who cannot ordinarily afford  
25 dental attention receive it?

26 DR. BERNIER: If you will allow me; it  
27 is often said that the figures speak for themselves and  
28 we know that the number of dentists in the various  
29 regions of the province are as follows: in Montreal, with





1 a population of 1,800,000 people there are 756 dentists.  
2 In other words, there is one dentist for every 2,407  
3 people.

4 In Quebec, there are 400 dentists with  
5 a population of 308,000; in other words, there is one  
6 dentist for every 3,000 people.

7 In the other areas of the province  
8 there are 573 dentists for a total population of  
9 2,985,000. This, I feel, is partially the answer to  
10 the question that was just raised.

2 11 More specifically now to answer your  
12 question, I believe that in the urban areas clinical  
13 dental services are available to the public where  
14 treatment is given to children.

15 I believe in the suburban areas there  
16 are also some of the provincial sanitary units which  
17 give dental care to the children in the province.

18 COMMISSIONER STRACHAN: When you refer  
19 to sanitary units, that is the way it came through to  
20 me; could you describe them?

21 DR. RATTE: Sanitary units, as you know,  
22 are medical units and dentists are attached to these  
23 medical units. Some of the dentists work on a full-time  
24 basis and others on a part-time basis; they work two  
25 half days or two days per week and they deal principally  
26 with schoolchildren.

27 In the sector which is covered by a  
28 sanitary unit a dentist will visit all the schools and  
29 he will give dental hygiene teaching and treat as many  
30 children as possible and apparently this treatment is







1 given without any distinction of economic conditions  
2 of the children; no distinction is made between who  
3 need care and the old people will receive care within,  
4 of course, the limitations of the dentists' time.

G/dpw 5 COMMISSIONER STRACHAN: You have recom-  
6 mended coverage of welfare assistance children under a  
7 voluntary plan administered by the College. How would  
8 you provide care for others under social welfare?

9 DR. RATTE: Mr. Chairman, we have  
10 prepared, for the Provincial Government, a dental  
11 service plan for needy children. If you will allow me,  
12 I will read forth the summary of this plan. I also  
13 have a copy, if you wish to peruse it.

14 For the benefit of the population and  
15 the dental profession this program should be in conformity  
16 with certain basic interests. First, the treatment of  
17 children should be carried out in the dentist's own  
18 office. We insist on this because this is a prerequisite  
19 to first-class treatment and also the relationship  
20 between the dentist and his young patient, and we elimi-  
21 nate the shame of receiving free treatment.

22 Provision will be provided for free  
23 choice of the dentist, and also the dentist will have  
24 the right to refuse any patient. All aspects of the  
25 plan concerning dental care, such as examination, diag-  
26 nosis and treatment and prophylaxis are determined by  
27 representatives of the dental profession.

28 Fourthly, these same representatives  
29 should state the amount of their fees for major treatment.

30 Fifth, the plan must be explicit with







1 respect to the type and number of treatments granted.

2 Eligibility - all members of the dental  
3 profession who are duly registered with the College of  
4 Dental Surgeons of the Province of Quebec. They will  
5 give treatment to all children under 16 years of age,  
6 as directed by the Government.

7 Payment will be made by the College of  
8 Dental Surgeons, which will act as an intermediary  
9 between the Government and the dentists.

10 Treatment plan eligibility - children  
11 under 16 years of age as determined by the Government,  
12 and with an identity card to be given by the Ministry  
13 of Public Welfare.

14 We recommend that the plan includes the  
15 following groups: needy children, which covers about  
16 70,000 children; the agency children, which are about  
17 some 11,000 in number. These children are placed by  
18 the Welfare Ministry with private families. The public  
19 welfare children amount to some 4,600 in number. We  
20 presume that children in institutions and in welfare  
21 agencies will continue to receive dental services, either  
22 by designated dentists, or they will be distributed  
23 among all the dentists of the region.

24 The type of treatment to be given -  
25 examination, obturation, synthetic porcelains, extractions,  
26 x-rays of the rear teeth, prophylactic treatment, tempo-  
27 rary crowns.

28 Even if the program is incomplete it  
29 will ensure the patient treatment. The matter of occlu-  
30 sions and deformations in the palate will be done in the





1 out-patient clinics of designated hospitals.

2 Fees - a fee scale will be set up by  
3 the College of Dental Surgeons of the Province of Quebec  
4 according to which dentists' bills will be paid to the  
5 dentist himself.

6 The Ministry of Social Welfare will  
7 distribute identity cards to the beneficiaries, who will  
8 request these cards. The dentist will fill out these  
9 treatment forms, indicating the date of the treatment,  
10 the nature of the treatment, and the fee.

11 He is responsible to the parents of the  
12 child. After the treatment he will prepare a file on  
13 the case, which will be distributed to the administrative  
14 offices, the Ministry of Social Welfare and the College  
15 of Dental Surgeons will see to it that an intermediary  
16 is provided between the dentist and the Government.

17 The College will pay the dentist directly  
18 from a fund fed by a payment of one dollar or more, that  
19 the Ministry of Social Welfare will pay each month for  
20 each child treated.

21 The explanation of the operation of this  
22 plan will be furnished by the Ministry of Public Welfare  
23 to each beneficiary. The dentist does not have the right  
24 to ask fees directly of the patient which he has accepted  
25 to treat. Only authorized fees can be charged.

26 The College of Dental Surgeons will  
27 furnish all dentists with information concerning the  
28 operation of this plan.

29 If we have chosen as a basis those  
30 children who are under social welfare, it is because







1 this system should go through a trial period. It should  
2 serve as a basis for a more developed system, which would  
3 include other children, and also care can be administered  
4 to old people, the aged. This will be the basis of a  
5 system which, in time and with experience, can be applied  
6 to all those who are unable to pay for their dental care.

7 COMMISSIONER STRACHAN: Thank you very  
8 much, Dr. Ratte, for reading that into the record of the  
9 Commission. I am sure it will be useful to us.

10 DR. OLIVER: I wonder if I might  
11 clarify the translation of that into English in certain  
12 respects?

13 If the Department of Welfare pays the  
14 College of Dental Surgeons for each child eligible, not  
15 for each child treated, the dollar is paid for each child  
16 eligible.

17 THE ACTING CHAIRMAN: Does that mean  
18 that if there is a shortage in the fund, the dentists  
19 will pro-rate their fees?

20 DR. OLIVER: No, I believe what would  
21 happen there is that there would be a dollar paid for  
22 each child eligible, of which there are some 90,000  
23 possibly, but of that 90,000 the ones who would actually  
24 receive treatment, or present for treatment, would be  
25 actually much smaller.

26 THE ACTING CHAIRMAN: Yes, that is  
27 quite true, but let us suppose there was \$90,000 taken  
28 into the fund and when all the bills came in you might  
29 get more children than you expected, and there may be  
30 \$100,000-worth of bills, so is the dentist then paid 90







1 cents on the dollar?

2 DR. RATTE: Our intention when we say  
3 one dollar or more is that as the plan is implemented  
4 an adjustment will be made between the College and the  
5 Government, so that the fees paid to the dentists  
6 shall be fees for first-class work.

7 THE CHAIRMAN: Then what you are saying  
8 in effect then is that you are estimating that \$90,000  
9 might cover the fees for the first year, and if it was  
10 more you would expect the Government to make it up, and  
11 if it was less presumably the College would refund to  
12 the Government?

13 DR. RATTE: Yes, we expect that, but I  
14 think you understand that this \$90,000 is for one month.  
15 It is one dollar a month or more according to the adjust-  
16 ment to be made in the plan, because it cannot be less  
17 than one dollar according to the preliminary studies we  
18 have conducted.

19 THE ACTING CHAIRMAN: Thank you very  
20 much. Miss Girard?

21 COMMISSIONER GIRARD: The plan which  
22 you advocate is a plan for indigent children. At the  
23 present time do the indigent children not receive dental  
24 care individually, or by dentists attached to the school  
25 commissions and schools?

26 DR. RATTE: Some of these children  
27 receive care, but most of those are urgent cases, emer-  
28 gencies, and not complete treatments, such as we advocate  
29 as a basic service. I think that even in the health  
30 units the number of fillings which can be made is very





1 limited in comparison with the number of fillings, or  
2 rather extractions I mean, because I don't have any  
3 exact information, but from memory I can say that one  
4 year there were 12,000 fillings against 80,000 extrac-  
5 tions, so it is rather a tooth-pulling than a filling  
6 service.

7 COMMISSIONER GIRARD: If 1,455 children  
8 were to arrive at the dentist's office, would you have  
9 enough staff to take care of the children?

10 DR. RATTE: Well, if you divide 80,000  
11 children by 1,400 it does not make a very big figure,  
12 and of course you have to remember that out of this  
13 figure there are a number of them who are already being  
14 treated, and wouldn't be treated under the new plan,  
15 because the children who are in protective institutions,  
16 and in other bodies, and organizations, are already  
17 treated by dentists who are appointed for that purpose.

18 COMMISSIONER STRACHAN: Have you any  
19 recommendation by which others under the welfare plan  
20 would be treated?

21 DR. RATTE: For the present, so long as  
22 a basic plan is not implemented or started in application,  
23 and as long as the function of the organization has not  
24 approved its value, I don't think we can accept more  
25 than we propose, but it may be expanded in the future.

26 COMMISSIONER STRACHAN: Turning somewhat  
27 to the rural situation, and referring in particular to  
28 paragraph 9 on page 2, you state:

29 "Financial encouragement for the dentist  
30 undertaking to practise for several







1 years in rural areas."

2 Have you any concrete suggestions?

3 This is a problem which is spread across Canada, and  
4 we would appreciate any suggestions you might have in  
5 respect to this. How it might be implemented.

6 DR. LE BLANC: Most dentists are rather  
7 desirous of having their practice in town. That is the  
8 reason for which we have very few dentists in rural  
9 areas, and I think some benefit should be given to the  
10 dentists who wish to go to remote areas, where the  
11 proportion of dentists in relation to inhabitants is  
12 very unfavourable.

13 So what we have thought of and might  
14 suggest, perhaps, is a system approximately similar to  
15 that which has been instituted by the Army. That is to  
16 say that a dentist would take a commitment to exercise  
17 for five years in a rural area, and in exchange, if he  
18 were a student he would receive payment of his studies,  
19 at least during the last year, and the payment of two-  
20 thirds of his equipment, which is very expensive,  
21 following which, after five years, the equipment would  
22 become his property, and I think that financially it  
23 would not be very difficult to attain that.

24 That is approximately the only plan we  
25 see at the present time. It works in the Army. Each  
26 year, as in other provinces incidentally, the Army pays  
27 for the studies of students who go into the Army for  
28 five years and that is what we would like to see in  
29 order to give an incentive for certain dentists to go  
30 into the remote areas, which they do not do for many







1 social reasons. Many of them are accustomed to towns;  
2 many of them marry; their wives, who are young, do not  
3 want to go to remote areas where life is more difficult  
4 and social relationships are more difficult, so certainly  
5 something would have to be done to help them and give  
6 them an incentive to go out into the country.

7 DR. OLIVER: It had crossed our mind  
8 on this problem that if there were a method of the local  
9 municipality, businessmen or others, receiving a tax  
10 rate, as you might say, to put one of their local boys  
11 through dentistry, he is much more likely to come back  
12 and serve in the local community, rather than one who  
13 is from an urban area to begin with. It is very difficult  
14 to take a chap and put him in another small area where,  
15 as I say, the social amenities for bringing up their  
16 own families, the school and so on, do not offer the  
17 same opportunities, and cultural opportunities for the  
18 chap's family, whereas a home-town boy might be inclined  
19 to go back, particularly if he were financed by home-town  
20 people.

B/dpw

21 DR. RATTE: The problem is also connected  
22 with the degree of dental education, the program of  
23 dental education in rural areas. In order that the  
24 population better appreciate dental service I think the  
25 two things are intimately connected.

26 COMMISSIONER STRACHAN: Thank you,  
27 gentlemen and particularly Dr. Ratte; that was going to  
28 be my next question. Regarding the students from rural  
29 areas, is it the feeling of the College that students  
30 who come from rural areas are more likely to go back or





1 do they come back? Is it a high percentage go back?

2 DR. RATTE: Yes, a very large percentage,  
3 but I don't think more than 60% go back. It also depends  
4 where they come from. If they come from a small village  
5 where there are not a great many facilities they don't  
6 go back. They try to install their practice in a place  
7 of three or four thousand inhabitants, fairly close to  
8 their home village or home town, but generally speaking,  
9 when they spend a few years in town, and particularly  
10 if they marry a girl who lives in town, the case is a  
11 lost cause.

12 COMMISSIONER STRACHAN: Coming to  
13 another subject; is your College in favour of prepayment  
14 plans for dental services operated by the profession on  
15 a non-profit basis?

16 DR. BERNIER: I think that the College  
17 would be in favour of the idea of a prepayment plan for  
18 dental services, but I must say that a company recently -  
19 I forget the name - the registrar could certainly give it,  
20 who has made an attempt in that sense and I think it was  
21 a fruitless attempt, but the College would certainly  
22 have no objection to developing a prepayment plan for  
23 dental services, of course, on a non-profit basis.

24 Quite naturally, the plan would be  
25 administered by the College which already has a co-opera-  
26 tion of services for dental health it has established  
27 and to which we could certainly add members who would  
28 receive dental care and who would be interested in a  
29 plan.

30 COMMISSIONER STRACHAN: This plan







1 suggested or mentioned, at least, in the last paragraph  
2 number 34 is not in actual operation. Is that one  
3 sponsored by your College?

4 DR. LE BLANC: It is a plan which has  
5 been organized by a group including 400 families. The  
6 people in this building here, in the International  
7 Civil Aviation Organization, who have contacted us,  
8 their system is a private system that they wish to  
9 administer themselves. They ensure, that is to say,  
10 the adherents pay a premium and they have a refund for  
11 each dental act performed by dentists selected by its  
12 employees. In that case we have - it has nothing to do  
13 with the College, with our organization; the people go  
14 to the dentist they select. The dentist bills him. He  
15 describes the work done and charges the proper price,  
16 the price which he feels to be the proper price for  
17 that care and the insured person goes to his company,  
18 sort of an insurance company, and is refunded a certain  
19 amount.

20 Unfortunately a majority vote was  
21 required by the 400 families and there were votes  
22 lacking and the plan is not in operation, I learned the  
23 other day. It is most unfortunate. There are plans  
24 working well in the United States, not many, but there  
25 are some. It would seem the insurance companies that  
26 have organized these groups of individuals have by now  
27 no complaints, they don't lose any money; whereas most  
28 insurance companies have refused to deal with dental  
29 care, stating the premiums would be too high if they  
30 want to go into dentistry.







1 We have several plans, pilot plans,  
2 which are being tried similar to that in the United  
3 States and here. We had hoped to have this one. It  
4 would give us very accurate information. Unfortunately  
5 a number of families didn't wish to follow the sugges-  
6 tions so the plan is still pending.

7 DR. RATTE: Mr. Chairman, this part  
8 of our presentation, generally speaking, implies we are  
9 ready to co-operate and to supply all groups who wish  
10 to establish plans, to give full co-operation to put  
11 a plan into operation.

12 COMMISSIONER STRACHAN: Thank you very  
13 much, gentlemen. Regarding the dental hygienist situation  
14 in the province, we were informed yesterday that there  
15 are none being trained. What do you say of the future  
16 regarding dental hygienists?

17 DR. LE BLANC: The question of dental  
18 hygienists is one which has been dealt with by the  
19 College. It had been in existence for a long time. As  
20 said yesterday it was dealt with by the College three  
21 years ago by the establishment of regulations of dental  
22 hygienists in the Province of Quebec. They are approxi-  
23 mately similar to the regulations in force in other  
24 provinces.

25 As Registrar, I must say that I have  
26 had only two or three applications at the present time  
27 from the United States and I haven't had a single dental  
28 hygienist registered, but we shall take the necessary  
29 action to facilitate it, pending the time when we may  
30 have schools, to facilitate the coming of girls from the

which are being raised similar to that in the United States and here. We had hoped to have this one. It would give us very accurate information. Unfortunately a number of families didn't wish to follow the suggestion as the plan is still pending.

DR. RATTIE: Mr. Chairman, this part of our presentation, generally speaking, implies we are ready to co-operate and to supply all groups who wish to establish plans, to give full co-operation to get a plan into operation.

COMMISSIONER STUBBART: Thank you very

much, gentlemen. Regarding the dental hygienist situation in the province, we were informed yesterday that there are none being trained. What do you say of the future regarding dental hygienists?

DR. LE HANE: The question of dental

hygienists is one which has been dealt with by the College. It had been in existence for a long time. As said yesterday it was dealt with by the College three years ago by the establishment of regulations of dental hygienists in the Province of Quebec. They are approximately similar to the regulations in force in other

provinces.

As Registrar, I must say that I have had on a two or three applications at the present time from the United States and I haven't had a single dental hygienist registered, but we shall take the necessary action to facilitate it pending the time when we may have schools to facilitate the coming of girls from the



1 United States or from Toronto or other places where  
2 schools exist. I have to make arrangements with the  
3 immigration service to facilitate the trip for girls  
4 from the United States and I am told it will be very  
5 easy for them to come and work with the dentists here.

6 At the beginning it will be a training  
7 period. It is our desire, our hope possibly to organize  
8 one of the proposed two schools of dental hygiene in  
9 our faculty, one faculty at Montreal and one at McGill.

10 However, for financial reasons, and  
11 perhaps for space reasons in the case of McGill, there  
12 will be some delay, but I have good hopes that within a  
13 year-and-a-half or two years we may have the first  
14 school at the faculty at Montreal.

15 Dental hygienists seem to us to be  
16 persons who will be extremely useful, not only for the  
17 dentists, but for the population. The girl who is a  
18 dental hygienist working in a dentist's office may give  
19 great service and I think from the point of view of jobs  
20 rather fastidious to the dentist, which is prophylaxy  
21 or the cleaning of teeth.

22 They will be able to do that. They can  
23 also do radio, take x-rays, develop films and so forth,  
24 but they can do other things. They can immediately  
25 contact the children; in particular, children arriving  
26 at the office for the first time.

27 I think from the point of view of public  
28 relations these young ladies have, in the United States,  
29 done a great deal to propagate dentistry in that country.

30 If the U.S. dentists are very much







1 appreciated and esteemed by the U.S. population I think  
2 that is due, in great part, to the propaganda work  
3 done by these girls every day with the customers,  
4 because they become very devoted to their dentist and  
5 they quite sincerely sound the praises of the dentist for  
6 whom they work.

7 COMMISSIONER STRACHAN: Have you any  
8 training program or do you favour a training program  
9 for dental assistants and technicians?

10 DR. LE BLANC: For dental assistants  
11 we have no organized program. We are thinking of that,  
12 because we are finding out more and more that the girls  
13 supplied by dentists in their offices, dentists who are  
14 very busy and don't always have time to instruct the  
15 girls properly, becoming more and more difficult, so  
16 we have been thinking of setting up a sort of night  
17 school where girls who are competent, or even girls who  
18 are now working with the dentist could receive extra  
19 courses by faculty professors, dentists or by assistants  
20 who are already qualified, but we have nothing going,  
21 nothing done so far in that field.

22 We have a great deal of projects on  
23 hand, but nothing has been completed.

24 COMMISSIONER STRACHAN: Have you any  
25 provisions in mind regarding technicians?

26 DR. LE BLANC: In the case of techni-  
27 cians, we have in the Province of Quebec, an Association  
28 of Dental Technicians. That Association has been consti-  
29 tuted since 1944 and at the present time comprises 385  
30 dental technicians who are members in due form of their

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1 Association. There are economists; there are schools.  
2 They have teachers. There are also teachers from both  
3 faculties who give courses. They have a five-year  
4 apprenticeship, partially in their school and partially  
5 in laboratories, and for the present time, that is a  
6 satisfactory situation.

7 Now, we have a sufficient number of  
8 dental technicians to meet the demand of the number of  
9 dentists we have, but it is going to be - we are working  
10 in co-operation with the Association and we are on good  
11 terms with the Association of Technicians.

12 There are also a large number of legal  
13 ones who are working also, if you are interested in that.  
14 They are legal from the point of view of the Association  
15 of Technicians and from our own point of view.

16 That exists everywhere so there is  
17 nothing special to our province.

18 COMMISSIONER STRACHAN: Thank you.  
19 You answered my question in your last remark.

20 Coming to a subject that was once  
21 mentioned yesterday, you suggested a need for expansion  
22 of dental schools or new schools. How can this need  
23 best be met, by expansion or by new schools?

2 24 DR. BERNIER: Mr. Chairman, gentlemen,  
25 I think that the College of Dental Surgeons of the  
26 Province of Quebec would rather be in favour of the idea  
27 of a new dental school. This is for a number of reasons.  
28 There is the economic point of view, the geographic  
29 point of view and the psychological point of view. The  
30 University of Laval in Quebec, at the present time,

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1 dispenses teaching which covers the disciplines or  
2 fields. We have a School of Medicine which is an  
3 organization through which we may extract, we have a  
4 good source. We have competent professors who can  
5 give the teaching. We also have faculties in science,  
6 chemistry and so forth which can co-operate in the  
7 establishment of a dental faculty, and concepts of  
8 hygiene have considerably developed in the last 20 years,  
9 and I think that the demand for curative and prophylactic  
10 dental care will become expanded to the point where the  
11 dental profession in this province may not, perhaps,  
12 be able adequately to meet the requirements of the popula-  
13 tion.

14 The economic factor,, as I think you  
15 are well aware of, arises with us with the same acuteness  
16 as the rest of the country. No doubt you are aware that  
17 a student in dental surgery must spend approximately  
18 \$3,300 for lodging and food. His teaching fees may  
19 reach \$3,412 according to a recent census, and his  
20 expenses for installation may run from \$7,000 to \$10,000,  
21 which would be a total minimum figure of approximately  
22 \$13,712.

23 Obviously, for the student living at  
24 the limits of the province, say, in Gaspesia, where  
25 this travel to the metropolis will raise a very serious  
26 question mark for him, and he will have to envisage  
27 fairly considerable sums to follow a course in dental  
28 surgery.

29 However, on the other hand, we have at  
30 the present time about 40 classical colleges which



part of teaching which covers the disciplines in

fields. We have a school of medicine which is an

organization through which we may extract, we have a

good number. We have competent professors who can

give the teaching. We also have facilities in relation

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establishment of a dental faculty, and concepts of

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dental care will become expanded to the point where the

dental profession in this province may not, perhaps,

be able adequately to meet the requirements of the popula-

tion.

The economic factor, as I think you

are well aware of, arises with us with the same acuteness

as the rest of the country. No doubt you are aware that

a student in dental surgery must spend approximately

\$4,500 for lodging and food. His teaching fees may

reach \$4,500 according to a recent census, and his

expenses for installation may run from \$7,000 to \$10,000,

which would be a total minimum figure of approximately

\$16,000.

Consequently, for the student living at

the limit of the province, say, in Guelph, where

the cost of the metropolitan will make a very serious

burden on him, and he will have to envisage

that the metropolitan aims to follow a course in dental

medicine.

However, on the other hand, we have in

the present time about 40 classical colleges which



1 deliver the B.A., which are affiliated with the Univer-  
2 sity of Laval in closer geographical proximity. I  
3 think it is quite normal for the student to prefer to  
4 undertake university studies in the city closest to his  
5 domicile where sometimes he may find with friends or  
6 with relatives accommodation which may reduce his costs  
7 of study considerably.

8                   The matter of transport is also a  
9 major one, and I think the cost of living index is  
10 perhaps a little lower in a town such as Sherbrooke,  
11 Quebec, than in a large metropolis.

12                  That briefly covers the three aspects  
13 of the problem and we are quite concerned in a  
14 different direction on our existing faculties; that is  
15 to say, in the case of the University of Montreal, for  
16 instance, which is the only French-speaking university  
17 in North America, I believe it teaches dental surgery  
18 and will continue to give regular courses oriented  
19 toward post-graduate studies to the great advantage of  
20 dentists of this province who often don't adopt a  
21 second language as well as their native language and I  
22 think that as a provincial corporation we would have  
23 great advantage in orienting one of our faculties in  
24 this direction.

25                  The present faculties now are filled.  
26 I know for this year they are filled to capacity, maximum  
27 capacity. That might not have been the case in the last  
28 few years, but as I stated earlier, students coming  
29 from the limits of the province hesitate to adopt a  
30 profession such as ours; He might not have quite as much

1. The first part of the A.A. which are affiliated with the University

2. of the level in closer geographical proximity. I

3. think it is quite normal for the student to prefer to

4. undertake university studies in the city closest to his

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25. capacity. They might not have been the case in the last

26. year, but as I stated earlier, students coming

27. from the limits of the province hesitate to adopt a

28. location and so on; it might not have quite as much





1 hesitation were he to find a centre closer to his domi-  
2 cile where expenses would be certainly less.

3 The setting up of a dental faculty is  
4 only one point in the program conceived by the College  
5 of Dental Surgeons in the province for the solution to  
6 the adequate number of dentists. I think it is a point  
7 of some importance.

8 If we refer to other installations or  
9 experiments, I would refer to the College of Manitoba,  
10 which has the largest number of students now in dental  
11 surgery pro rata to the population.

/PMcH/dpw

12 I have given a few figures earlier  
13 stating that 573 dentists care for 2,980,500 persons  
14 or one dentist per 1,502 in the province. I think this  
15 is one of the most unfavourable figures in all Canada.  
16 I think a new faculty would perhaps, within a few years,  
17 fill in this very wide margin which exists between the  
18 pro rata of dentists to population in urban centres as  
19 compared to rural centres or areas.

20 The two dental faculties, Montreal and  
21 McGill, can give us from 1961 to 1964 about 291 new  
22 dentists; from that number 94 or one-third are not  
23 resident in the Province of Quebec. During the same  
24 period 1961 to 1964 about 110 dentists will reach the  
25 age of 65 years. About 20 of your 291 new graduates  
26 are non-residents, 20 retire and 20 are deceased; a  
27 total number of about 67 dentists between now and 1964-65,  
28 161; so we can easily see there is a flagrant dispropor-  
29 tion between the number of new graduates and the population  
30 increase.

restoration was to find a centre closer to his home. The where expenses would be certainly less.

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I have given a few figures earlier stating that 573 dentists care for 2,980,500 persons or one dentist per 1,500 in the province. I think this is one of the most unfavourable figures in all Canada. I think a new faculty would perhaps, within a few years, fill in this very wide margin which exists between the two rates of dentists to population in urban centres as compared to rural centres or areas.

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period 1961 to 1964 about 110 dentists will reach the

end of 5 years. About 20 of your 291 new graduates

are non-residents, 20 retire and 20 are deceased; a

net number of about 67 dentists between now and 1964-65,

but we can easily see there is a flagrant disproportion

between the number of new graduates and the population

there.



1 In addition, we note that the number  
2 of students for this profession in this province have  
3 been decreasing since 1957 when it went from 4.5 per  
4 100,000 population to 3.9 whereas for the rest of Canada  
5 it remained approximately stable at 4.6 students per  
6 100,000 population.

7 I have attempted briefly to sum up  
8 the situation but if you wish for more detail I will  
9 attempt to answer your questions to the best of my  
10 ability.

11 COMMISSIONER STRACHAN: Thank you very  
12 much. What dental research is carried on in the  
13 province and how should dental research be encouraged  
14 throughout the Dominion?

15 DR. RATTE: Dental research in the  
16 Province of Quebec is carried on mainly on a private  
17 scale in the dental faculties. I would recommend the  
18 establishment of an institute for dental research, a  
19 Canadian Dental Research Institute, which would bring  
20 together all research work carried on in each of our  
21 dental schools or elsewhere, if there are other insti-  
22 tutes.

23 All this knowledge and the exchange of  
24 views between all these groups would serve to create a  
25 research system which would probably meet the needs of  
26 our country.

27 The cause of dental caries, of course,  
28 does not vary amongst the various provinces so in this  
29 area there should be close co-operation and funds should  
30 be placed at the disposal of such an institute. It would







1 be up to the provinces, I feel, to train their own  
2 research specialists.

3 COMMISSIONER STRACHAN: Thank you, Dr.  
4 Ratte. I am sure you would not wish me to disappoint  
5 the members of the Commission by not making some  
6 reference to fluoridation. What, in your opinion, are  
7 the main obstacles to the adoption of this public health  
8 measure, fluoridation?

9 DR. LE BLANC: Obviously we have been  
10 advocating fluoridation for a number of years now because  
11 we know it is very useful in reducing caries, parti-  
12 cularly with respect to children.

13 However, it is quite obvious that this  
14 measure is very easy to apply; it costs almost nothing  
15 and it can reduce caries by about 50% to 60%. Conse-  
16 quently, this is a measure which should be generalized  
17 and our government, therefore, should impose it on the  
18 public and not leave it up to the public to decide  
19 whether or not it wishes fluoridation. This is the view-  
20 point of our College on the matter of fluoridation.

21 COMMISSIONER STRACHAN: Thank you very  
22 much.

23 THE ACTING CHAIRMAN: Dr. Van Wart?

24 COMMISSIONER VAN WART: Are general  
25 anaesthetics given in dentistry?

26 DR. OLIVER: Do you mean by that, given  
27 by the dentist or given to dental patients?

28 COMMISSIONER VAN WART: No, to dental  
29 patients.

30 DR. OLIVER: Oh yes, without that means

for up to the present, I feel, to train their own

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COMMISSIONER STACHAN: Thank you, Dr.

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COMMISSIONER VAN NELLE: Are general

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by the dentist or given to dental patients?

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Dr. OLIVER: Oh yes, without that means





1 we would be very seriously handicapped.

2 COMMISSIONER VAN WART: Where are they  
3 usually given?

4 DR. OLIVER: Well, where facilities  
5 allow they are given in hospitals but equally given -  
6 I should not say "equally" given but facilities can be  
7 arranged and provided by competent anaesthetists bringing  
8 their equipment with them.

9 COMMISSIONER VAN WART: Are there dental  
10 services in all the hospitals?

11 DR. OLIVER: No, there are not dental  
12 services in all the hospitals.

13 COMMISSIONER VAN WART: Are there out-  
14 patient or in-patient?

15 DR. OLIVER: A combination of both.  
16 Some of our more serious procedures such as surgical,  
17 extreme surgical measures, the patient is hospitalized  
18 for several days whereas an out-patient procedure comes  
19 in in the morning and is out again in the afternoon; in  
20 many cases, particularly with children, we prefer them  
21 to come in the night before.

22 COMMISSIONER VAN WART: Are the dentists  
23 on the staff of the hospitals?

24 DR. OLIVER: There are some hospitals  
25 which have dental departments.

26 COMMISSIONER VAN WART: Are they  
27 allowed to admit patients themselves or do they admit  
28 through doctors?

29 DR. OLIVER: It depends entirely on the  
30 hospital. We have hospitals in Montreal where the

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1 dentists have an extremely good relationship with their  
2 medical confreres and they work under the department  
3 of surgery as a sub-department and they admit the  
4 patient.

5 Of course, every patient admitted is  
6 examined by a physician but in some instances they are  
7 not allowed to admit patients at all, which, of course,  
8 is quite an irksome affair for those who wish to carry  
9 out surgical procedures in a hospital.

10 COMMISSIONER VAN WART: Is there any  
11 difficulty in getting your patients admitted to hospitals?

12 DR. OLIVER: In some hospitals I believe  
13 it is very, very difficult.

14 COMMISSIONER VAN WART: Do the anaesthe-  
15 tists object to giving anaesthetics in the out-patient  
16 department?

17 DR. OLIVER: In the hospital I am  
18 familiar with there has been no objection from the  
19 anaesthetists to giving it in the out-patient although  
20 that is one of the most difficult phases of anaesthesia.

21 COMMISSIONER VAN WART: Coming to  
22 Section 32, you state that treatment will be given in  
23 the dentist's office and you insist on this condition  
24 as it ensures the finest care and best relationship  
25 between the young patient and his dentist.

26 You insist on your anaesthetic cases  
27 being done in the dentist's office?

28 DR. RATTE: No, we do not insist that  
29 general anaesthesia should be given in the dentist's  
30 office but in certain regions it is physically impossible



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between the out-patient and his dentist.

You insist on your anesthesia cases

being done in the dentist's office?

DR. OLIVER: No, we do not insist that

anesthesia should be given in the dentist's

office but in some regions it is practically impossible



1 to give general anaesthesia elsewhere than in the  
2 dentist's own office because of the remote distances  
3 of hospitals. I would say that the College has made a  
4 recommendation to the Federal Government and to the  
5 Hospital Association to the effect that all the provin-  
6 cial hospitals should have an adequate dental service  
7 with qualified personnel operating it, namely, dentists  
8 who have taken special courses to fit them to work in  
9 hospitals.

10 These dental services should be treated  
11 on the same scale as all the other specialized services  
12 in the hospital.

13 COMMISSIONER VAN WART: In insisting on  
14 dental services in dental offices under the plan I  
15 assume that you mean you are against the development of  
16 large-scale clinics in hospitals or in separate institu-  
17 tions to carry out this work with groups of dentists?

18 DR. RATTE: We consider that the best  
19 dental service is given when the dentist and his patient  
20 are in close contact, namely, in a private office. It  
21 has been demonstrated in the United States and elsewhere  
22 that dental services in clinics where several dentists  
23 work together; there is lack of personal contact between  
24 the dentist and his patient and it creates a problem.

25 The dental service given in these  
26 clinics is almost always of a lower quality than the  
27 type of service that can be given in a private dental  
28 office.

29 Furthermore, a young patient goes into  
30 these clinics when, as I say, he goes to these clinics

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...on the same scale as all the other specialized services  
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COMMISSIONER VAN WART: In talking on  
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The dental service given in these  
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...that can be given in a private dental  
...office.

Furthermore, a young patient goes into  
...as I say, he goes to these clinics





1 for treatment and thereafter he loses contact with his  
2 own dentist. Our planned private office treatment  
3 would lead to a situation where a child who has been  
4 treated in a private office would have a certain close  
5 contact with his dentist and this relationship would  
6 continue throughout the rest of the patient's life.

7 COMMISSIONER VAN WART: This would  
8 apply to the so-called indigent.

9 COMMISSIONER FIRESTONE: Dr. Langlois,  
10 I shall present my questions to you but please feel free  
11 to call on your colleagues to deal with the questions.

12 Dr. Langlois, is there a shortage of  
13 dental surgeons in the Province of Quebec?

14 DR. LANGLOIS: Yes.

15 COMMISSIONER FIRESTONE: Could you give  
16 us your estimate of how large that shortage is?

17 DR. LANGLOIS: With respect to the popula-  
18 tion in the metropolitan region of Montreal we have 656  
19 dentists for a population of 1,819,000 which makes it  
20 one dentist for 2,470 people in population.

21 In the Quebec region there are 404  
22 dentists for 304,000 population which means one dentist  
23 for 3,400 in the population.

24 In the urban area you have 573 dentists  
25 for 2,700,000 population which makes one dentist for  
26 every 5,200 people in the population.

27 COMMISSIONER FIRESTONE: How many  
28 dentists are you short? You have only given me the  
29 figures as to how many dentists you have but my question  
30 is, how many dentists are you short?





1 DR. BERNIER: Well, I believe the ideal  
2 situation would be to give the figures prepared in the  
3 United States, namely, one dentist 1,900 people in the  
4 population.

2 5 Of course, dental education in the  
6 United States is much more advanced in this respect  
7 than it is here but the ideal figure for Quebec would  
8 be 2,500 dentists. I can say that we could not absorb  
9 all these dentists at the present time without under-  
10 taking an educational campaign on dental hygiene amongst  
11 the public.

12 The demand for care should also be under-  
13 taken by the public itself but this figure I have quoted  
14 would be the ideal figure.

15 COMMISSIONER FIRESTONE: Well, this  
16 would suggest the ideal figure and would mean another  
17 1,200 dentists. This would seem to be a very large  
18 figure but what would be a more realistic assessment of  
19 what you need in the Province of Quebec, the number of  
20 dentists to provide acceptable service, not only in the  
21 urban areas but the rural areas? What would be a more  
22 realistic figure than the 1,200 that you suggested as  
23 ideal; would it be 500 or 300 ---?

24 DR. BERNIER: 500 dentists would be a  
25 more realistic figure even with the project that we have,  
26 this plan for social welfare. I believe that in the  
27 next 10 years we may meet the demand for medical care  
28 of the type that we wish to give to the population  
29 according to the plan we have set forth this morning.

30 COMMISSIONER FIRESTONE: If you have



1. It is not possible to give the figures prepared in the

2. The figures for each year are given in the report

3. This is a very good idea for Quebec would

4. be 1,000,000. I can say that we could not absorb

5. all these dollars at the present time without under-

6. standing an educational campaign on dental hygiene among

7. the people.

8. The demand for care should also be under-

9. stood in the light of the fact that I have quoted

10. figures for the total figure.

11. The figures for the total figure and would mean another

12. 1,000,000. This would seem to be a very large

13. figure. It would be a more realistic assessment of

14. what we need in the Province of Quebec, the number of

15. dentists, the number of acceptable dentists, not only in the

16. urban areas but the rural areas? That would be a more

17. realistic figure than the 1,000 that you suggested as

18. being the number of dentists in the Province of Quebec?

19. The figure of 500 dentists would be a

20. more realistic figure even with the fact that we have

21. a very low level of dental welfare. I believe that in the

22. next 10 years we may need the dental for medical care

23. in the rural areas we want to give to the population

24. the dental care we have and from that point

25. the dental care we have and from that point



1 presently a shortage of the order you have been speaking  
2 of, 500 dentists, and if, over the next three years, all  
3 you will be adding is 67 dentists, would it be correct to  
4 say that the situation is going to get worse unless some  
5 action is taken?

AG/dpw

6 DR. BERNIER: Quite so, sir.

7 COMMISSIONER FIRESTONE: And it therefore  
8 means that if no further action is taken the people of  
9 the Province of Quebec will get lesser dental services,  
10 rather than better dental services, or increased dental  
11 services. I should not say better because your quality  
12 is high, but your problem is that you have not got  
13 enough dentists to provide adequate services; is that  
14 correct, sir?

15 DR. BERNIER: Up to a certain point the  
16 statement you have made is quite correct. We have  
17 observed here, and I should like to make a digression  
18 here; we observed an abrupt increase from 1951 to the  
19 present time of the population in Quebec. Whereas for  
20 the years 1956-1957 we have noticed a considerable  
21 slump with respect to the population increase.

22 In 1958 there were a number of students,  
23 the number of students in our universities increased,  
24 but since 1958 this figure seems to be regressing during  
25 the past four years.

26 DR. LE BLANC: I should like to add  
27 that the situation is very difficult for us at the  
28 present time, because although we have 1,325 dentists  
29 practising at the present, amongst this number there  
30 are almost 200 dentists who are older than 65. There







1 are even some who are 76 years old practising. Under  
2 these conditions, and with the phenomenal increase in  
3 the population, because we can estimate that in 1970  
4 we will have 6,000,000 inhabitants or more, I do think  
5 that this rate of increase of dentists of 500 per year  
6 will suffice to meet even with 30 or 40 more dentists  
7 per year, because the population is more and more  
8 familiar with dental care at the present time, and it  
9 is more educated with respect to dental hygiene, and  
10 therefore it is asking for more care and more complex  
11 dental care.

12 Consequently, we need young dentists,  
13 well-trained dentists, and a great many of them, during  
14 the next 10 years.

15 COMMISSIONER FIRESTONE: Well, you have  
16 made, gentlemen, a very strong case for more dentists.  
17 I think you have some other comments, sir?

18 DR. OLIVER: This may arise somewhat  
19 from our statement that at the present time we are  
20 meeting the demand because the whole situation seems to  
21 hinge on that word "demand". The population needs  
22 dentistry, as we know, but the demand for it, particularly  
23 in some areas of unenlightenment, is that the demand for  
24 it is simply for extractions, and we train these highly  
25 skilled men, who go into areas where all they want to do  
26 is have teeth extracted.

27 We would like to see the public educated  
28 to demand good dentistry, and this is coming to the point  
29 where we will shortly, should the public demand, as we  
30 hope they will, more dentistry, we will be unable to cope





1 with it, and this is why we are stressing so much the  
2 preventive phase, fluoridation and so forth.

3 [unclear] COMMISSIONER FIRESTONE: I think,  
4 gentlemen, you have made the case that, one, that there  
5 is a shortage of dentists; two, this shortage is going  
6 to get worse; three, that there is a growing awareness  
7 of the public in the Province of Quebec for dental  
8 services, which will increase the demand.

9 [unclear] Do you gentlemen really think that on  
10 the basis of the proposals that you have made you will  
11 get a sufficient number of dentists in the next three  
12 to five years, to cope with this growing demand and the  
13 shortage that you have in existence?

14 [unclear] DR. LE BLANC: No, no. We believe it  
15 is absolutely impossible under these circumstances.  
16 Unless a miracle occurs it would be impossible for us  
17 to find an adequate number of dentists during the next  
18 10 years.

19 [unclear] You know, a dentist cannot be trained  
20 very quickly. It requires four years, plus pre-dental  
21 study. Under such conditions the situation is, I won't  
22 say desperate, but at least very difficult, and it forces  
23 every dentist to work at full capacity. This is not an  
24 ideal situation, because it may result in a reduction in  
25 the quality of care that is administered.

26 [unclear] However, we believe, and this is  
27 contained in our brief, we believe that there are enough  
28 dentists in 1962 to meet the demand. We are not certain  
29 of this, but we believe this to be true. However, it is  
30 impossible for us to estimate what the needs of the





With it, and it is very interesting to note that

the two main, the main, the main, the main

COMMISSIONER OF THE REVENUE: I think

that, you have made the case that, one, that, that

is a shortage of dentists; two, this shortage is going

to get worse; three, that there is a growing awareness

of the public in the Province of Quebec for dental

services, and that, that, that, that

Do you gentlemen really think that or

the basis of the proposals that you have made you will

get a sufficient number of dentists in the next three

to five years, perhaps with this growing demand and the

situation that you have in existence?

DR. LE BLANC: No, no. We believe it

is absolutely impossible under these circumstances.

Unless a miracle occurs it would be impossible for us

to find an adequate number of dentists during the next

10 years.

You know, a dentist cannot be trained

in a few months, it takes years, it takes years

and, I believe such conditions the situation as I won't

say anything, but at least very difficult, and it forces

us to consider to work at full capacity. This is not an

easy situation, because it may result in a reduction in

the quality of care that is administered.

However, we believe, and this is

the situation in the Province of Quebec, and this is

the situation in the Province of Quebec, and this is

of this, but we believe this to be true. However, it is

information as to the situation what the needs of the



1 population will be.

2                               Moreover, we would be unable to act if  
3 the population wished to obtain full treatment. We  
4 would be unable to meet the demand, because I understand  
5 that with respect to the question of needs, we only  
6 know them partially.

7                               Perhaps using electronic computers we  
8 might estimate the needs of the population, but electronic  
9 computers couldn't furnish the dental care required.

10                           COMMISSIONER FIRESTONE: You have said  
11 that only a miracle could achieve this quantity of  
12 dental services that would be required by an expanding  
13 population in the Province of Quebec requiring greater  
14 dental care. I wonder if you would consider, since it  
15 does not seem that you will be likely to get that number  
16 of dentists on the basis of the recommendations which  
17 have so far been made, whether an increased number of  
18 dental hygienists and auxiliaries could be trained to  
19 work under the supervision of dentists, say, one or two  
20 in each office, and these auxiliaries and dental hygienists  
21 be permitted to work in the mouths of the patients, under  
22 the supervision of a dental surgeon, and in this manner  
23 increase the productive capacity of all the dental  
24 offices across the province by a considerable proportion?

25                           DR. LE BLANC: Obviously if every dental  
26 office had a dental hygienist amongst its personnel it  
27 may well be that we could give more service to the popula-  
28 tion, because the time given by the dentist in educating  
29 and training his patients with respect to dental hygiene,  
30 or in prophylaxis, this is rather easy work, and this

1 decision will be.

2 Moreover, we would be unable to set it

3 the population wished to obtain full treatment. We

4 would be unable to meet the demand, because I understand

5 that with respect to the question of needs, we only

6 know them partially.

7 Perhaps using electronic computers we

8 might estimate the needs of the population, but electronic

9 computers couldn't furnish the dental care required.

10 COMMISSIONER FIRESTONE: You have said

11 that only a miracle could solve this quantity of

12 dental services that would be required by an expanding

13 population in the Province of Quebec requiring greater

14 dental care. I wonder if you would consider, since it

15 does not seem that you will be likely to get that number

16 of dentists on the basis of the recommendations which

17 have to be made now, whether an increased number of

18 dental hygienists and auxiliaries could be trained to

19 work under the supervision of dentists, say, one or two

20 in each office, and these auxiliaries and dental hygienists

21 be permitted to work in the homes of the patients, under

22 the supervision of a dental surgeon, and in this manner

23 increase the productive capacity of all the dental

24 services across the province by a considerable proportion?

25 DR. LE BLANC: Certainly if every dental

26 office had a dental hygienist amongst the personnel it

27 say well, then we could give more service to the population

28 than, because the time given by the dentist in consulting

29 and treating the patients with respect to dental hygiene,

30 or in restorations, this is rather easy work, and that





1 work indeed could be done by auxiliaries.

2 The dentist could, in this way, devote  
3 more of his time to more complicated cases, and this  
4 would, of course, be a considerable help to the popula-  
5 tion.

6 However, we are still awaiting the  
7 first dental hygienist to appear in Quebec, so we can  
8 hardly believe that within the next 10 years that we  
9 will have much more than 50 such hygienists, but in  
10 any case we are going to carry on a campaign to bring  
11 young Americans here, but we don't know how many will  
12 meet the demand, and we don't know how many dentists  
13 will be ready to take these people in their offices.

14 COMMISSIONER FIRESTONE: If there were  
15 in Canada introduced a national plan for dental care for  
16 schoolchildren ages 3 to 16, and assuming that that plan  
17 were also adopted in the provinces, all these plans  
18 would be provincially administered, of course, in line  
19 with our Constitutional division of responsibilities.

20 If such a plan were in operation, or  
21 were to come into operation, would you feel that such a  
22 plan could be handled within the next 10 years by the  
23 dental profession in the Province of Quebec, allowing  
24 for the growth of your profession as you expect it?

25 DR. RATTE: Mr. Chairman, Dr. Firestone,  
26 well, if such a plan were implemented it would have to be  
27 implemented gradually, so that there be no compulsion to  
28 treat all children from 5 to 16 years at once.

29 We must begin with the children when  
30 they begin school. We must apply the appropriate treatment

work indeed could be done by specialists.

The dentist could, in this way, devote

more of his time to more complicated cases, and this  
would, of course, be a considerable help to the patient.

Then,

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first dental hygienist to appear in Quebec, so we can

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will have much more than 50 such hygienists, but in

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COMMISSIONER FERNSTON: If there were

in Quebec introduced a national plan for dental care for

children between ages 3 to 16, and assuming that that plan

were also adopted in the provinces, all these plans

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were to come into operation, would you feel that such a

plan could be handled within the next 10 years by the

dental profession in the Province of Quebec, allowing

for the growth of your profession as you expect it?

Well, if such a plan were implemented it would have to be

implemented gradually, so that there be no interruption to

most of children from 5 to 16 years of age.

We must begin with the children when

they begin school. We must apply the appropriate treatment.



1 to their mouths and then carry on follow-up services  
2 during the ensuing years.

3 I believe that the dental profession  
4 could meet this problem in the following way: the fact  
5 that the public would be urged to participate in a  
6 dental care program would oblige the population to  
7 request more dentists, and force our universities to  
8 establish more dental schools, in order to meet this  
9 growing demand.

10 COMMISSIONER FIRESTONE: Would you feel  
11 that if such a plan were introduced, that it might be  
12 possible to telescope the implementation of the plan?

13 By telescoping, I mean reducing the  
14 time required to introduce the plan over a period of  
15 two to three years, rather than a period of 10 years.

16 If we had in Canada a system somewhat  
17 similar to what they have in New Zealand, whereby  
18 registered nurses with an additional two years of training  
19 can do a good part of dental work of a more simplified  
20 manner; under the direction of, let us say, in Canada,  
21 under the direction of dental surgeons?

22 DR. WARD: We don't believe in second-  
23 rate dentistry for children. We believe that children  
24 deserve the very highest service that we can provide.  
25 We often wonder sometimes if the suggestion was made  
26 that these girls work on the 40 to 50 age group what the  
27 reaction would be.

28 With reference to New Zealand problems,  
29 I believe we can point out that the adolescent group in  
30 New Zealand suffers considerably, because once they are







1 through treatment from these nurses there is a tremendous  
2 gap between the finishing of that treatment and the  
3 time when they get in the hands of competent dentists.

4 This is borne out by Canadian Dental  
5 Association research, and I believe some of these  
6 figures are in the brief which you so kindly read in  
7 Ottawa.

2 8 COMMISSIONER FIRESTONE: Is the sugges-  
9 tion that you are making that these nurses providing  
10 dental services in New Zealand provide a second-class  
11 service, not competent; is that what you are saying?

12 DR. WARD: No sir.

13 COMMISSIONER FIRESTONE: Or is the  
14 implication that there is a gap when the young people  
15 of 16 leave school until they are being looked after  
16 by dentists?

17 DR. WARD: The gap is the thing that I  
18 am concerned with.

19 COMMISSIONER FIRESTONE: But you are  
20 not commenting on the lack of quality of services that  
21 the dental nurses provide?

22 DR. WARD: I am not commenting on  
23 mechanical services, yes sir.

24 COMMISSIONER BALTZAN: You are talking  
25 about this type of plan with children 3 to 16. Would  
26 that contain a sort of bilateral feature in that if  
27 such a national plan came about, would it then compel  
28 the dentist to give this service to that group, and  
29 conversely, would it be compelling upon young people  
30 like that to be brought to the dentist, and what would



at least treatment from these nurses were in a treatment  
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 by dentists?

DR. WARD: The gap is the thing that I  
 am concerned with.

COMMISSIONER FIRESTONE: But you are  
 not commenting on the lack of quality of services that  
 the dental nurses provide?

DR. WARD: I am not commenting on  
 the quality of services, yes sir.

COMMISSIONER BATTAM: You are talking  
 about 11 days of pain with children 3 to 16. Would  
 that constitute a sort of bilateral feature in that if  
 not a bilateral pain came about, would it then compel  
 the dentist to give it to service to that group, and  
 consequently, would it be compelling upon young people  
 the need to be brought to the dentist, and what would





1 happen if the young people, or the mothers of young  
2 people, just failed to do that?

3 DR. RATTE: I don't believe sir that  
4 in a democratic country that we can force anyone to  
5 receive dental care. We live in a country where we  
6 are free to act as we see fit, and only through education  
7 should we bring the children and their parents to consult  
8 the dentist.

9 If today the percentage is 27.3% and  
10 if through an adequate program of dental care we can  
11 bring the figure up to 40 or 45%, I believe we will  
12 have made a great deal of progress.

13 COMMISSIONER FIRESTONE: May I come  
14 back to the comment that you have offered, sir? You  
15 said you didn't believe in second-class dental care for  
16 the children, and I quite agree with you. You want the  
17 best dental care to everybody in Canada to the extent  
18 that we have facilities available to provide this, and  
19 if we haven't got enough facilities we have to extend  
20 these facilities to provide the dental care.

21 Now sir, the problem we are facing in  
22 the Province of Quebec, as in other provinces, is that  
23 we do not seem to have on the horizon, according to the  
24 statements we have heard from the dental profession  
25 itself, the prospect of a sufficient number of dentists  
26 coming forth to provide the additional dental services  
27 required, including the implementation of a dental  
28 service program for all children of school age.

29 Now sir, the question arises, if we do  
30 not have enough dentists, why can we not strengthen the

...if one young couple, or the mother of young

...last failed to do that?

DR. RAY: I don't believe in that

...a democratic country that we can force anyone to

...dental care. We live in a country where we

...free to act as we see fit, and only through education

...and we bring the children and their parents to consult

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COMMISSIONER RIVINGTON: May I come

...back to the comment that you have offered, sir? You

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...now sir, the question arises, if we do

...not have enough dentists, why can we not strengthen the



1 dentists by training nurses to do some of the simpler  
2 work, and have the dentists and the trained dental  
3 nurses produce the sum total of dental services to  
4 provide dental services of good quality to all our  
5 children, because the alternative to what you gentlemen  
6 have been suggesting, of introducing the program in  
7 stages, means that children of certain age groups will  
8 get no dental services at all, except those whose  
9 parents can afford it, and from the percentages that  
10 you have given this is the minority.

11 So my question still is, why could  
12 you not visualize a program where dentists and well-  
13 trained dental nurses could together provide this  
14 treatment of children in schools?

15 DR. WARD: We think an expansion of the  
16 activities of the dental hygienists is certainly indicated,  
17 and they can do many things which would facilitate work  
18 in the office, but we do not believe that these girls  
19 should be trained on, let us say, a two-year course to  
20 provide service in the mouth.

21 Whether we would like it or not, then  
22 you are establishing a double standard of dentistry.

23 We were talking about recruiting. We  
24 might say why take four years of dentistry if you could  
25 become a dental nurse in two years? This is a philosophy;  
26 I am sorry, but it is difficult to explain.

27 COMMISSIONER FIRESTONE: If I may just  
28 understand the point, I will be very happy to come back  
29 to that point again. We would like to understand your  
30 philosophy, because your philosophy is based on providing





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might say why the four years of dentistry if you could  
become a dental nurse in two years? This is a philosophy.  
I am sorry, but it is difficult to explain.  
COMMISSIONER FISHBONE: If I may just  
reiterate the point, I will be very happy to come back  
to that point again. We would like to understand your  
philosophy, because your philosophy is based on providing



1 good dental services for the people of Canada, and the  
2 people of the Province of Quebec, and you have admitted  
3 that there are just not enough dentists to provide that  
4 service.

5 Now, where is your philosophy going  
6 wrong, when on the one hand you want to provide the  
7 best dental services for the people of the Province of  
8 Quebec and then you say, well, there are not enough of  
9 us around to provide and meet all those needs, and we  
10 are not in favour of anyone else helping us and working  
11 in the mouth, because that would be second-class?

12 How do you reconcile that philosophy,  
13 wishing to do good, and having a group that will not  
14 allow anybody to help you?

15 /PB/dpw DR. WARD: You have to have a standard  
16 and I believe this is what we would have to go for.  
17 You have a standard below which you don't feel that  
18 you can go. Our point here is that right at the moment  
19 as we have said in our brief we feel we can look after  
20 these things but with the slow expansion of the duties  
21 of auxiliary help, educating the public, we feel  
22 concerned that while there are rights to dental treatment,  
23 there are also responsibilities on the part of the people  
24 and that the people should practise preventive measures.

25 If we could get through to them dental  
26 caries is a curable, preventive disease, this miracle  
27 we talk about would really come true.

28 I might say I am in agreement with my  
29 colleague. If attention is given to oral therapy  
30 and pathological conditions other than caries this would

So dental services for the people of Canada, and the  
people of the Province of Quebec, and you have admitted  
that there are just not enough dentists to provide that

Now, where is your philosophy going

Well, when on the one hand you want to provide the  
best dental services for the people of the Province of  
Quebec and then you say, well, there are not enough of  
us around to provide and meet all those needs, and we  
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allow anybody to help you?

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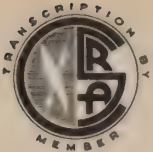
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1 raise the standard.

2 DR. OLIVER: For the simple work, I  
3 might use a little analogy; I know analogies are not  
4 always true. This is the same thing as having a  
5 jeweller's apprentice work on the wristwatch while the  
6 jeweller works on the alarm clock. We are taking these  
7 children, we as dentists are interested in the welfare  
8 of the children; who is going to look after our children  
9 and grandchildren?

10 We have something to say on that, too.  
11 This is not simple work. We don't consider this simple  
12 work at all. As a matter of fact, after the dentist  
13 finishes six years of college training he will take  
14 another year post-graduate work to be a pedadontist,  
15 to work especially on children.

16 That is how intricate we feel this  
17 working on children is. The limitations alone call for  
18 all types of psychology and handling them, and we don't  
19 feel this is good enough.

20 Now, as an alternative, our alternative  
21 is to put it right up to the public and say "We think  
22 if you think of this as a preventive disease, fluoridate  
23 your water and cut out sugar and sweets" if they affect  
24 the people. We know some people some people can eat  
25 these confections without trouble. Some of them can't.

26 We say use these preventive measures  
27 and let us work on the children. If you want to bring  
28 in some auxiliaries let us have them work on adults.  
29 I think that would be limiting in about two years time.  
30 We would have the adults saying "We want the dentist to



raise the standard.

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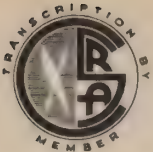
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I think that would be limiting in about two years time.

We would have the adults saying "We want the dentist to



1 work on us."

2 COMMISSIONER FIRESTONE: This actually  
3 means, you have pointed out to us this morning, that  
4 there is a serious shortage of dentists and there are  
5 difficulties in implementing a program of covering all  
6 schoolchildren given the existing supply of dentists  
7 and expected supply.

8 Do you still feel that the recruitment  
9 of dental nurses who would also be working in the mouth  
10 of the patient under supervision of the dentist would  
11 not assist the dental profession in the Province of  
12 Quebec to help implement such a program?

13 You would prefer to do it yourself  
14 knowing you can't do it yourself because there aren't  
15 enough dentists available.

16 DR. OLIVER: I think, Dr. Firestone,  
17 if I may add there is a difference in the word "need"  
18 and "demand". At the present time we can do this. We  
19 are in horror of the great demand we couldn't fill.  
20 We would like that demand to take place along with  
21 preventive measures.

22 If you install, as we say, a two standard  
23 rate of dentistry you are going to cut off the possible  
24 training of further dentists because dentists will not,  
25 as has been shown in New Zealand, where the nurse is  
26 allowed to do this work.

27 I believe personnel is a serious  
28 hindrance, the training of dental personnel and advances  
29 in dental research.

30 COMMISSIONER FIRESTONE: You see, sir, if





means, you have pointed out to us this morning, that there is a serious shortage of dentists and there are difficulties in implementing a program of covering all schoolchildren given the existing supply of dentists and expanded supply.

Do you still feel that the recruitment of dental nurses who would also be working in the mouth of the patient under supervision of the dentist would not reduce the dental profession in the Province of Quebec to help implement such a program?

You would prefer to do it yourself knowing you can't do it yourself because there aren't enough dentists available.

If I say and there is a difference in the word "need" and "demand". At the present time we can do this. We are in danger of the great demand we couldn't fill. We would like that demand to take place along with the existing resources.

If you insist, as we say, a two-standards rate of dentistry you are going to cut off the possibility of further dentists because dentists will not, as we know in New Zealand, where the price is raised to the point where

I believe personnel is a serious obstacle, the training of dental personnel and advances in dental research.



1 some of these children could be looked after both by  
2 dentists supported by nurses then perhaps more dentists  
3 might be available to look after adults and you are  
4 saying you need more dentists for both children and  
5 for adults.

6 DR. OLIVER: On a short term this  
7 would answer, shall we say, the promise to look after  
8 everybody. We will promise - on the long term it  
9 could end up with a drop of standards of our profession  
10 and what is more important, the people of Canada  
11 would have a low-grade type of dentistry in the long  
12 pull. It is hard to face in the short pull.

13 Thus by following preventive measures and  
14 getting the standard of dentistry up to where it belongs;  
15 the great profession it is. If it starts to go down  
16 we are the ones, and our children are the ones, that  
17 are going to suffer.

18 COMMISSIONER BALTZAN: Along this line  
19 of questioning, I think I heard this said yesterday:  
20 that fluoridation will eventually reduce the number of  
21 dentists required by one-third per unit of population.

22 DR. OLIVER: I have heard the figure  
23 quoted that it would be the same thing as graduating  
24 200 dentists. I think these are figures, of course.

25 COMMISSIONER BALTZAN: With the arguments  
26 that are going on, should this take place you think you  
27 have a good future prospect by this?

28 DR. OLIVER: Yes.

29 DR. RATTE: I would like to reply to  
30 Dr. Firestone. What we are proposing is a plan under

some of these children could be looked after both by dentists supported by nurses then perhaps more dentists might be available to look after adults and you are saying you need more dentists for both children and for adults.

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everybody. We will promise - on the long term it

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dentists required by one-third per unit of population.

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200 dentists. I think these are figures, of course.

COMMISSIONER BARTMAN: With the arguments

that are going on, should this take place you think you

have a good future prospect by that?

DR. OLIVER: Yes.

DR. BARTMAN: I would like to reply to

Mr. Bartman, what we are proposing is a plan under





1 which there would be preventive measures which would  
2 serve to reduce the need for a greater number of dentists  
3 because there would be less treatment to be given.

4 Secondly, we propose the establishment  
5 of new dental faculties in order to provide a greater  
6 number of dentists.

7 Thirdly, we propose the establishment  
8 of dental hygiene schools which, apparently, would give  
9 our dentists the opportunity to increase their working  
10 hours by 30% and these factors taken together constitute  
11 the program that we are advocating.

12 I wouldn't want to see a situation in  
13 which the nurse or hygienist would give treatment. Let  
14 us begin with the beginning. Let us give our population  
15 dentists and dental hygienists at first, and then if we  
16 can't solve the problem then we would look for other  
17 solutions.

18 DR. BERNIER: Dr. Ratte expressed, more  
19 or less, my own opinion on this point. It is a rather  
20 important matter, this lack of dentists. It is quite a  
21 fact, sir, but there are other factors which are still  
22 more important; namely, prophylaxis and education of  
23 the public.

24 Prophylaxis, if we have the means  
25 available and if the Government doesn't want to make  
26 these means obligatory for the population, we can't do  
27 anything about it. These are the first steps to take  
28 in order to treat dental caries.

29 Thereafter, of course, we could proceed.

30 COMMISSIONER FIRESTONE: There are

which there would be preventive measures which would serve to reduce the need for a greater number of dentists because there would be less treatment to be given.

Secondly, we propose the establishment of new dental facilities in order to provide a greater number of dentists.

Thirdly, we propose the establishment of dental hygiene schools which, apparently, would give our dentists the opportunity to increase their working hours by 30% and these factors taken together constitute the program that we are advocating.

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DR. BERNIER: Dr. Rattie expressed, more or less, my own opinion on this point. It is a rather important matter, this lack of dentists. It is quite a fact, and, too, there are other factors which are still more important; namely, prophylaxis and education of the public.

Prophylaxis, if we have the means available and if the Government doesn't want to make them means obligatory for the population, we can't do anything about it. These are the first steps to take in order to treat dental caries.

Thereafter, of course, we could proceed.



1 factors which we really haven't discussed including  
2 economics, education, preventive dentistry, but I want  
3 to say thank you gentlemen for your helpful comments  
4 in giving us to understand what you call the philosophy  
5 of the dental profession. Thank you.

6 THE ACTING CHAIRMAN: I think what  
7 Dr. Ratte and the other gentlemen were really saying;  
8 that they are willing to let a dental nurse take care  
9 of a lost cause like myself, but people for whom there  
10 was some hope, they wanted a higher quality of dental  
11 care.

12 There is just one point I would like to  
13 touch upon. We were told yesterday that the most economic  
14 and quickest way of increasing the output of dentists  
15 in this province would be by expanding the physical  
16 facilities of the University of Montreal which we were  
17 told, with the present faculty, and if the proper  
18 students were available, could increase its intake with  
19 its physical facilities, by 50%.

20 In other words, a class of 60 would go up  
21 to a class of 90. You have asserted that it should be  
22 at Laval or Sherbrooke. What you have to say about that?

23 DR. RATTE: Mr. Chairman, in dental  
24 surgery there are certain students which have to be  
25 received in order that the teaching can be the best  
26 possible, and it has been established that dental  
27 faculties having a number greater than 50 or 60 graduates;  
28 in that case, the contact between the professor and the  
29 student, and also the teaching, has become less good.

30 It is possible that at the University







1 of Montreal there might be a slight increase; could we  
2 increase the number of students? It is possible. I  
3 don't think it would be a good movement to go to 90 or  
4 100 students because teaching wouldn't have the quality  
5 it has now.

6 I must say, at the University of  
7 Montreal, the teaching is very good at the present time,  
8 but what we advocate is another centre of dental educa-  
9 tion because we wish to decentralize teaching and thereby  
10 we are not - for instance, not only are we creating  
11 facilities in Quebec for dental teaching; we are  
12 creating another centre of radiation from the point of  
13 view of dental surgery.

14 Quebec being the centre of the region  
15 it can't be done otherwise than the dental schools  
16 should radiate or it should become the medium for  
17 dental teaching.

18 THE ACTING CHAIRMAN: The point that  
19 was made yesterday was, of course, the difficulty in  
20 obtaining competent teaching staff quickly at a new  
21 faculty.

22 Incidentally, coming from Toronto I am  
23 a little shocked by your statement that over 50 or 60  
24 is the optimum school. I will have to report to Dean  
25 Ellis. We will have to cut our schools in half.

26 The suggestion now is that this should  
27 be the first step because we now have the high quality  
28 teaching staff. You are suggesting that the staff wouldn't  
29 be able to take up an extra 25 or 30 students?

30 DR. BERNIER: I think, Mr. Chairman,



1 of Montreal there might be a slight increase; could we  
2 increase the number of students? It is possible. I  
3 don't think it would be a good movement to go to 30 or  
4 100 students because teaching wouldn't have the quality  
5 it has now.

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7 Montreal, the teaching is very good at the present time,  
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19 was made yesterday was, of course, the difficulty in  
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27 be the first step because we now have the high quality  
28 teaching staff. You are suggesting that the staff wouldn't  
29 be able to take up an extra 25 or 30 students?

30 THE CHAIRMAN: I think so, Chairman.





1 that in order to fill the present gaps, as Dr. Ratte  
2 explained, it might be possible for the University of  
3 Montreal to do some expansion of its material and  
4 physical facilities.

2  
5 Therefore, nevertheless, in my opinion  
6 there is this geographical problem that we are attempting  
7 to resolve. Since our two dental, present dental facul-  
8 ties are situated in the same city, and consequently  
9 the same part of the province, we might attract a fair  
10 number of Bachelors in the Province of Quebec who are  
11 coming out of the classical colleges in the area exten-  
12 ding from Three Rivers to Gaspesia into another centre  
13 than Montreal and this would resolve what is the problem  
14 in our province, which is a particular problem since we  
15 are French-speaking.

16 As I was explaining earlier, the  
17 University of Montreal played a very important part by  
18 developing this first graduate school which would fill  
19 the major gap to the benefit of the entire population  
20 of professional dentists in the province.

21 Even if in our present schools we haven't  
22 seen full complements in the last few years, I think  
23 that one of the causes of the lack was the very great  
24 deal of travelling that the young people must engage in  
25 in order to obtain dental teaching in our province.

26 COMMISSIONER FIRESTONE: Thank you  
27 very much.

28 COMMISSIONER STRACHAN: I can tell you  
29 what Dean Ellis will say. Units of 60 are optimum for  
30 teaching purposes and 60 goes into 124 reasonably well.



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Even so in our present schools we haven't  
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COMMISSIONER STACHAN: Thank you  
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1 THE ACTING CHAIRMAN: Thank you, Dr.  
2 Strachan. Thank you Dr. Langlois and gentlemen for  
3 coming here this morning; for the time you have taken  
4 in preparation and for this very interesting and informa-  
5 tive discussion.

6 Your representation will certainly  
7 receive careful consideration by the Commission. The  
8 brief that you presently filed is Exhibit No. 215.

9 I understand that Dr. Baer is here  
10 representing the Mount Royal Dental Society of Montreal  
11 and he has a brief which will be Exhibit 216.

12  
13 --- EXHIBIT NO. 216: Submission of the Mount Royal  
14 Dental Society.

15 THE ACTING CHAIRMAN: You correct me,  
16 Dr. Baer; my understanding was that you merely wanted  
17 to present this brief and have it on the record and  
18 that the discussion which has taken place and of which  
19 you have been a participant, takes care of the situation  
20 as far as your group is concerned?

21 DR. BAER: The Mount Royal Dental  
22 Society, being purely a scientific society, its members  
23 feel very little could be contributed that hasn't  
24 already been contributed from the M.D.C. and the College  
25 of Dental Surgeons. We don't have the access or the  
26 facilities or the necessary figures and facts that your  
27 Commission requires.

28 Nevertheless, if there is anything that  
29 we can explain in our brief we would place ourselves at  
30







1 the disposal of your Commission. Thank you.

2 THE ACTING CHAIRMAN: I have read your  
3 summary, I have read the brief and I have looked over  
4 the summary and recommendations and it seems to me  
5 within the limited field in which your Society operates  
6 that there is nothing in those recommendations that has  
7 not been brought before us either by the College of  
8 Dental Surgeons or the Dental Society of Montreal.

9 There is nothing that is in your  
10 recommendations that is inconsistent with the recommenda-  
11 tions we have already heard. That being the situation  
12 I don't think the Commission have any questions. If  
13 there is any point on which you would like to make a  
14 statement now you are very welcome to do so.

15 DR. BAER: Conclusions. The Mount  
16 Royal Dental Society endorses the views of the College  
17 of Dental Surgeons of the Province of Quebec, namely:

- 18 1) that dental services are rendered  
19 most efficiently, with the best utiliza-  
20 tion of time and personnel and in the  
21 most conducive environment only in  
22 private offices;
- 23 2) that the patient must have the  
24 right to be treated by the dentist of  
25 his or her choice;
- 26 3) that the dentist must have the right  
27 to prescribe treatment according to his  
28 best judgment;
- 29 4) that the patient and the dentist  
30 deal directly with regard to fees, not



the interest of your Commission. Thank you.

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3) that the dentist must have the right

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best judgment;

4) that the patient and the dentist

deal directly with regard to fees, etc.





1 through a third party intermediary.

2 I would like to explain the philosophy  
3 of the Mount Royal Dental Society; namely, that the  
4 problems facing the dental profession present a unique  
5 challenge insofar as the problem can be attacked at  
6 both ends.

7 You have already from members of this  
8 delegation that personnel is not the only way of  
9 attacking the problem. Prevention is probably equally  
10 as important.

11 If I may interject another analogy.  
12 If we were to liken our problem to that of a lawn  
13 fattened by weeds. You can put the weed-killer on at  
14 the beginning and one man can look after the maintenance.  
15 If you wait until it becomes a jungle you have to send  
16 out an army to clean it up.

17 It is the same with our problem. That  
18 may illustrate what I mean.

19 THE ACTING CHAIRMAN: Thank you very  
20 much, Dr. Baer and gentlemen. We will now take a ten-  
21 minute recess.

22  
23 --- Short Recess  
24  
25  
26  
27  
28  
29  
30



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of the Mount Royal Dental Society; namely, that the  
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THE ACTING CHAIRMAN: Thank you very

much, Dr. Baer and gentlemen. We will now take a ten-  
minute recess.

--- Short recess



cH/dpw

1 THE ACTING CHAIRMAN: The next submission  
2 is the submission of The Quebec Society of Occupational  
3 Therapists and the brief will be known as Exhibit No.  
4 217.

5  
6 --- EXHIBIT NO. 217: Submission of The Quebec Society  
7 of Occupational Therapists.

8  
9 SUBMISSION OF THE QUEBEC SOCIETY OF  
10 OCCUPATIONAL THERAPISTS

11 Appearances: Mrs. J. Bernd  
12 Miss N. Dunkin  
13 Miss J. Forbes  
14 Mrs. L. Quastel  
15 Mrs. S. Perrodeau  
16 Mrs. L.C. Smith  
17 Dr. V. Goldbloom

18 THE ACTING CHAIRMAN: Mrs. Bernd, if  
19 you would introduce your associates and then proceed  
20 with the summary and conclusions and recommendations.

21 MRS. BERND: Mr. Chairman and members  
22 of the Commission: first of all, my associates, reading  
23 from the left, are Miss Lila Quastel, Miss Josephine  
24 Forbes, Miss Naomi Dunkin, Mrs. L.C. Smith, Dr. Goldbloom,  
25 who is counsel to the Association and Mrs. Perrodeau.  
26 I would like to present a summary of the conclusions  
27 and recommendations in the brief which we have submitted  
28 to you.

29 The rapid development of rehabilitation  
30 services in Canada in recent years has resulted in  
greatly increased demands for the services of the Occupa-  
tional Therapist in the fields of both physical and mental  
disability. Within the Province of Quebec, there are now





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STATEMENT OF THE ACTING CHAIRMAN

Apparatus: Mrs. J. Bernd  
Miss J. Forbes  
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of the Commission: First of all, my associates, reading

who is counsel to the Association and Mrs. Ferdeau.

I would like to present a summary of the conclusions and recommendations in the brief which we have submitted

to you.

The rapid development of rehabilitation

services in Canada in recent years has resulted in

greatly increased demands for the services of the occupa-

tional therapist in the fields of both physical and mental

disability. Within the Province of Quebec, there are now



1 rehabilitation units ranging from large centres to small  
2 units attached to hospitals. This rapid expansion has  
3 caused a widening gulf between demand for and supply of  
4 fully qualified Occupational Therapists required to meet  
5 the needs of the community. Despite the existence of  
6 two Schools of Occupational Therapy within the Province  
7 of Quebec, there is a great deficit of qualified personnel,  
8 both in the present situation and in anticipated future  
9 needs.

#### 10 DEFINITION

11 Occupational Therapy is a medically  
12 directed treatment service for the physically and/or  
13 mentally disabled person, using activities drawn from  
14 the normal components of an average day (i.e., work,  
15 self-care and recreation), with particular emphasis on  
16 interpersonal relationships; this service is aimed at  
17 maximum recovery of function for the individual and  
18 restoration of the individual to what for him/her is a  
19 meaningful place in the community, thus enabling him/her  
20 to be as socially, emotionally, physically and economi-  
21 cally independent as possible.

22 Occupational Therapy should be included  
23 in the health services available in general hospitals,  
24 rehabilitation centres, institutions for the chronically  
25 ill and aged, paediatric hospitals, and psychiatric  
26 hospitals.

27 At present there is a serious shortage  
28 of qualified Occupational Therapists in the Province of  
29 Quebec. It is obvious that the discrepancy between the  
30 number of hospital beds currently serviced by Occupational

hospitalization units ranging from large centres to small units attached to hospitals. This rapid expansion has caused a widening gulf between demand for and supply of fully qualified Occupational Therapists required to meet the needs of the community. Despite the existence of two Schools of Occupational Therapy within the Province of Quebec, there is a great deficit of qualified personnel both in the present situation and in anticipated future needs.

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1 Therapy and the total number of hospital beds in the  
2 province must be alleviated. There are 58 Occupational  
3 Therapists practising in this province, seven of whom  
4 are employed in the area of specific academic teaching.  
5 The remaining 51 Therapists represent a ratio of 1:178  
6 in hospitals with established Occupational Therapy  
7 departments, and a ratio of 1:1000 to the overall caseload  
8 in the institutions in the province.

9 It is recommended that the desirable  
10 ratio of Occupational Therapists to patients be 1:70.

11 This shortage of qualified Occupational  
12 Therapists is aggravated by frequent staff changes and  
13 by lack of support from some medical and administrative  
14 departments.

15 The present lack of qualified Occupa-  
16 tional Therapists leads to the employment by some  
17 institutions of:

- 18 a. unqualified personnel who are
- 19 termed 'occupational therapists' but
- 20 who lack the appropriate training;
- 21 b. Occupational Therapists being
- 22 replaced by persons of other disci-
- 23 plines whose training has been in
- 24 recreational, technical or educational
- 25 skills but has not been related to the
- 26 treatment of mental or physical disa-
- 27 bility;

28 In addition to this, newly graduated  
29 Occupational Therapists are pressured into accepting  
30 senior positions which demand more experience than they



therapy and the total number of hospital beds in the province must be alleviated. There are 58 Occupational Therapists practicing in this province, seven of whom are employed in the area of specific academic teaching. The remaining 51 Therapists represent a ratio of 1:173 in hospitals with established Occupational Therapy departments, and a ratio of 1:1,000 to the overall caseload in the institutions in the province.

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institutions of:

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1 can offer.

2 At present the greatest deficit of  
3 personnel is in the psychiatric field, where Occupational  
4 Therapy is of prime importance as an adjunctive treatment  
5 in psychotherapy.

6 It is recommended that:

7 a. Institutions state a minimum contract  
8 of one year when hiring an Occupational  
9 Therapist.

10 b. Considerably more detail, in terms  
11 of orientation and the use of Occupa-  
12 tional Therapy, be given to medical  
13 students, both in theoretical and  
14 practical settings, and that Medical  
15 Associations keep their members  
16 informed of current developments in  
17 rehabilitation procedures, with empha-  
18 sis on the role of para-medical  
19 personnel, including Occupational  
20 Therapists.

21 c. Qualified Occupational Therapists  
22 be consulted in the planning of Occu-  
23 pational Therapy departments and  
24 programmes.

25 If the health services in this province  
26 continue to expand, it is clear that there will be an  
27 increasing deficit of personnel and treatment facilities.

28 The need for adequate home treatment  
29 programmes is becoming more and more apparent, as  
30 evidenced by frequent requests for home service in





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continue to expand, it is felt that there will be an  
increasing reliance on paraprofessionals and treatment facilities.  
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and services is becoming more and more apparent, as  
evidenced by the present emphasis on home services in



1 almost every field. This Society feels that home-care  
2 programmes in Occupational Therapy should be developed  
3 as an extension of the services offered by established  
4 Occupational Therapy departments in hospitals and  
5 related institutions, since this would ensure maintenance  
6 of the best standards of Occupational Therapy.

7 It is recommended that:

- 8 a. More persons be trained as fully  
9 qualified Occupational Therapists;  
10 b. that if out-patient services are  
11 to be covered under the Hospital  
12 Insurance Act, the Provincial Govern-  
13 ment of Quebec consider the anticipated  
14 increase in caseload, and augment  
15 salaries of Occupational Therapists  
16 accordingly, through provision of  
17 grants for this purpose, and enable  
18 hospitals and related institutions  
19 to increase their complement of  
20 Occupational Therapists;  
21 c. that more Occupational Therapy  
22 departments be established, particu-  
23 larly in non-metropolitan areas;  
24 d. that sheltered employment facilities  
25 be extensively developed in the  
26 Province of Quebec.

27 Existent sheltered workshops can serve  
28 only a very small proportion of the total number of  
29 persons requiring such services. In many instances,  
30 this results in the overcrowding of Occupational Therapy







1 departments by patients who are not discharged when they  
2 have attained maximum benefit from Occupational Therapy,  
3 as discharge at this time might cause regression unless  
4 an immediate referral to sheltered employment were  
5 available. To avoid such regression, the patient is  
6 retained on the Occupational Therapy department caseload  
7 on a supportive programme, reducing the availability of  
8 facilities for active treatment cases.

9 Present educational facilities in  
10 Occupational Therapy in the Province of Quebec are not  
11 sufficient to meet anticipated needs.

12 It is recommended that:

13 a. All universities within the Province  
14 of Quebec with an existent Faculty of  
15 Medicine establish and maintain  
16 separate courses in Physiotherapy and  
17 Occupational Therapy, with basic  
18 academic courses in common to permit  
19 dual qualification if desired by the  
20 individual. It is emphasized that  
21 such courses should conform to the  
22 minimum standards established by the  
23 Rehabilitation Committee of the  
24 Canadian Medical Association, in  
25 collaboration with the Canadian  
26 Association of Occupational Thera-  
27 pists, for Schools of Occupational  
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29 b. Appropriate degree courses in  
30 Occupational Therapy be included in



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1 the long-term planning of existent  
2 and future Schools of Occupational  
3 Therapy in the province.

4 c. Greater publicity within High  
5 Schools and the community at large  
6 be initiated.

7 d. Existent and future courses in  
8 Occupational Therapy be opened to  
9 male applicants.

10 e. In order to attract more applicants,  
11 the Provincial Government of Quebec  
12 should augment the salaries for  
13 Occupational Therapists in hospitals  
14 and institutions under the Hospital  
15 Insurance Act.

16 f. Additional Occupational Therapy  
17 departments, staffed by qualified  
18 Occupational Therapists, be established  
19 to facilitate clinical training  
20 programmes.

21 g. The number and scope of bursaries  
22 be increased to encourage students to  
23 enter this field and to continue  
24 studies on a post-graduate level.

25 The average cost of training for the  
26 student is \$2,000.00 per annum. A limited number of  
27 bursaries are available, with restriction of many of  
28 these to those students enrolling in Degree courses.

29 THE ACTING CHAIRMAN: Thank you very  
30 much, Mrs. Bernd. Now, is there anything you would





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much, this demand. Now, is there anything you would



1 like to add, any particular portion of the brief on  
2 which you would like to expand or do any of your  
3 colleagues wish to speak before we turn it over to the  
4 members of the Commission?

5 MRS. BERND: I feel that the emphasis  
6 throughout the whole brief has been on the shortage  
7 of qualified occupational therapists in this province  
8 which has reverberations in the educational position;  
9 we will need more.

10 I think as we go through the brief we  
11 keep hitting the same point time and time again; it is  
12 a matter of not enough people to supply the kind of  
13 service we should to the patients.

14 THE ACTING CHAIRMAN: Thank you very  
15 much. You mention the home care programs; would those  
16 be hospital-based programs?

17 MRS. BERND: Our feeling was that the  
18 best standard of occupational therapy could be maintained  
19 through home services where the therapist would be  
20 employed by hospitals or institutions and would be on a  
21 home service assignment that would be supervised by  
22 qualified therapists in these hospitals and rehabilitation  
23 centres as well and would provide a service which would  
24 perhaps lead to actual attendance on a patient outside  
25 of the institution.

26 THE ACTING CHAIRMAN: That would also,  
27 I suppose, in many cases, facilitate an earlier discharge  
28 of patients from the hospital?

29 MRS. BERND: Yes, it could.

30 THE ACTING CHAIRMAN: Are there any such

live to add, my particular portion of the brief on

which you would like to expand or do any of your

colleagues wish to speak before we turn it over to the

members of the Commission?

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throughout the whole brief has been on the shortage

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of the institution.

THE ACTING CHAIRMAN: That would also,

of patients from the hospital?

MRS. BIRN: Yes, it could.

THE ACTING CHAIRMAN: Are there any other





1 hospital-based programs in existence today?

2 MRS. BERND: I know of one in Montreal  
3 at present which would include occupational therapists  
4 specifically although there is a lot more scope for  
5 programming if they have the therapists to staff the  
6 programs.

7 THE ACTING CHAIRMAN: There is one and  
8 it is hospital-based; which hospital is that?

9 MRS. BERND: A rehabilitation centre,  
10 the Montreal Therapy and Rehabilitation Centre.

11 THE ACTING CHAIRMAN: Is that program  
12 covered by the Hospital Insurance Act?

13 MRS. BERND: No, it is not. The  
14 service is offered by this home service physiotherapy  
15 and occupational therapy where it is indicated and we  
16 have the use of dual-trained therapists for want of  
17 duplication of personnel.

18 THE ACTING CHAIRMAN: For the purpose  
19 of the Hospital Insurance Act that is looked on as an  
20 out-patient service and is not covered?

21 MRS. BERND: I think so, yes.

22 THE ACTING CHAIRMAN: I take it that  
23 most of the members of your profession are employed in  
24 public general hospitals? That would appear to be the  
25 case if you turn to the table on page 6.

26 MRS. BERND: That is correct. I think  
27 at this point the greatest deficit is in the psychiatric  
28 field.

29 THE ACTING CHAIRMAN: Yes, that is  
30 where the greatest proportion of deficit appears to be



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1 although in number you show a greater deficit in the  
2 public general hospital. The point I am trying to make  
3 is this: you emphasize in the brief, first, that you  
4 must have better conditions of employment, particularly  
5 security of tenure and salary if you are going to attract  
6 people; that is one means of attracting them.

7 Two, you have pointed out the desirability  
8 of having males enter the profession and you have  
9 indicated that the salary scales would probably inhibit  
10 that.

11 What I am suggesting is, you correct  
12 me if you agree or do not agree; what I am suggesting  
13 is that the principal employer of your profession is  
14 the Quebec Hospital Services Commission through its  
15 control of hospital budgets and, therefore, that is  
16 a matter that is completely within its hands; do you  
17 agree with that?

18 MRS. BERND: I would think so.

19 COMMISSIONER VAN WART: On page 3A and  
20 also on page 5 you state that more persons be trained  
21 as fully qualified occupational therapists. Have the  
22 Canadian schools adequate facilities and staff to turn  
23 out many more occupational therapists?

24 MRS. SMITH: Yes, I think the enrolment  
25 in the schools is less than the schools can handle. One  
26 of the other problems is that we find girls tend to go  
27 to school at the schools which are fairly adjacent to  
28 their homes and if there is not a school of occupational  
29 therapy within a reasonable distance they are apt to go  
30 into some other professional group although they may be





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agree with that?

MRS. BROWN: I would think so.

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out many more occupational therapists?

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of the major problems is that we find girls tend to go  
to school at the schools which are fairly adjacent to  
their homes and if there is not a school of occupational  
therapy within a reasonable distance they are apt to go  
into some other professional group although they may be



1 interested in occupational therapy.

2 I could quote that in the order of  
3 Toronto where we did a survey of the number of students  
4 attending the University of Toronto. Out of 232  
5 students, 194 of them came from a radius of 100 miles  
6 of the city and the others were beyond that distance.

7 It is felt that girls of this age group  
8 tend to select education which is more closely at hand.

9 COMMISSIONER VAN WART: Do you feel  
10 that there are adequate facilities in Canada to train  
11 enough occupational therapists to meet the demand?

12 MRS. SMITH: I do not think so. There  
13 are new schools developing; in the last two years there  
14 have been three new schools developed in the western  
15 provinces and up until then the only schools were in  
16 Ontario and Quebec.

17 This submission today refers primarily  
18 to the situation within this province. Across Canada  
19 the demand has been greater in other areas because  
20 there were no schools and it was very difficult to get  
21 the girls from the provinces where the schools were to  
22 go out to other parts of the country.

23 Consequently, we find that in the  
24 western provinces the greater proportion of therapists  
25 employed have come to Canada from other countries; we  
26 need them and they do alleviate the shortage to some  
27 extent.

28 However, they are, by and large, a  
29 transient group and this results in not enough continuity  
30 of programming and frequent changes of staff, which is







1 detrimental to programming and also an expensive proce-  
2 dure.

3 COMMISSIONER VAN WART: In other fields  
4 we have been told that the number of people coming to  
5 Canada to enter those fields is lessening in the last  
6 few years; has that been the case in your field?

7 MRS. SMITH: No, I would say it is  
8 increasing in our field.

9 COMMISSIONER VAN WART: There is one  
10 other question. On page 10, with regard to the shelter  
11 workshops; are there many shelter workshops in the  
12 Province of Quebec?

13 MRS. BERND: There are very few; I can  
14 think of perhaps two or three.

15 COMMISSIONER VAN WART: Are they concen-  
16 trated in one area?

17 MRS. BERND: As far as I know they are  
18 in Montreal itself.

19 COMMISSIONER VAN WART: Do you feel  
20 there should be more sheltered workshops?

21 MRS. BERND: Very definitely.

22 COMMISSIONER VAN WART: Have you any  
23 suggestions to offer how you would get more sheltered  
24 workshops in Quebec?

25 MRS. BERND: Well, I think that at the  
26 present, the need for them is being established in any  
27 area where we have hospital and rehabilitation treatment  
28 because you come to a dead-end with quite a large propor-  
29 tion of your patients.

30 A sheltered workshop, either on a



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COMMISSIONER VAN WART: In other fields

we have been told that the number of people coming to Canada to enter those fields is lessening in the last few years; has that been the case in your field?

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other question. On page 10, with regard to the shelter workshops; are there many shelter workshops in the Province of Quebec?

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suggestions as to other how you would get more sheltered

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MRS. BERNHARD: Well, I think that at the

present, the need for them is being established in my

mind of your committee.

A sheltered workshop, either on a



1 temporary or a permanent basis, may provide the answer.  
2 How these things can be established I think would really  
3 depend on the individual municipality and treatment  
4 services.

5 COMMISSIONER VAN WART: Can the present  
6 sheltered workshops take patients from other parts of  
7 the province or must they all be confined to the  
8 community where the workshop is?

9 MRS. BERND: I would think the majority  
10 of the patients would be from the adjacent community  
11 because of the problem of housing.

12 Some of the patients may require  
13 special care. I do not know of any agency with a  
14 policy where they will not take patients from other  
15 establishments. This is usually a matter of a long  
16 waiting list and who happens to be at the head of the  
17 list.

18 I think possibly the question of public  
19 education is something that would help a great deal in  
20 this field and it is certainly something that the support  
21 of voluntary organizations should be considered in.

22 COMMISSIONER VAN WART: Thank you.

23 COMMISSIONER GIRARD: Mrs. Bernd, on page  
24 5 you locate the 58 occupational therapists in the  
25 province as 44 plus 7 in Montreal and the suburbs,  
26 Quebec City, 6 and Three Rivers, 1. Does this mean  
27 that in any of the sanatoria or psychiatric hospitals  
28 outside of these areas there are no occupational thera-  
29 pists?

30 MRS. BERND: Yes.





temporary or a permanent basis, may decide the answer.  
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depend on the individual municipality and treatment  
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COMMISSIONER VAN NANT: Can the pressure  
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the province or must they all be confined to the  
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of voluntary organizations should be considered in.

COMMISSIONER VAN NANT: Thank you.

COMMISSIONER GIBSON: Mr. Berlin, on page  
2 of the 28 occupational therapists in the  
province as at the 1st of March and the suburbs,  
about 10,000 and 15,000 more, it has this mean  
that in the of the province or occupational hospital.  
Some of these cases there are no hospital and there



1 COMMISSIONER GIRARD: You said  
2 psychiatric hospitals but I am interested in sanatoria  
3 because there are a number of them outside of these  
4 centres?

5 MRS. BERND: That is right.

6 COMMISSIONER GIRARD: So in this type  
7 of hospital there are not any at all?

8 MRS. BERND: Not now, no.

9 COMMISSIONER GIRARD: On page 8, this  
10 pertains to a question on education; you say:

11 "It is recommended that considerably  
12 more detail, in terms of orientation  
13 and the use of occupational therapy  
14 be given to medical students, both  
15 in theoretical and practical settings."

16 I think you refer in other places to  
17 more education of the public at large should be done  
18 regarding occupational therapy; I see it is not just  
19 the public at large, you also want more education of  
20 the occupational therapy given to the medical profession.

21 Do you feel a number of physicians do  
22 not know too much about occupational therapy or do not  
23 refer patients to occupational therapists when they can  
24 benefit by it?

25 MRS. BERND: I feel that a good number  
26 of members of the medical profession have just never  
27 known about what occupational therapy had to offer their  
28 patients, and therefore the best use is not made of the  
29 profession in terms of comprehensive treatment programs  
30 for their patients.



psychiatric hospitals but I am interested in hospitals  
because there are a number of them outside of these

COMMISSIONER GILMAN: So in this type

of hospital there are not any at all?

MRS. HENRY: Not now, no.

COMMISSIONER GILMAN: On page 4, this

pertains to a question on education; you say:

"It is recommended that considerably  
more detail, in terms of orientation  
and the use of occupational therapy  
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the occupational therapy given to the medical profession.

Do you feel a number of physicians do

not know too much about occupational therapy or do not

refer patients to occupational therapists when they can

benefit by it?

MRS. HENRY: I feel that a good number

of members of the medical profession have that notion

that when they send occupational therapy to other clinics

or hospitals, and therefore the best use is not made of the

profession in terms of comprehensive treatment program

for these patients.





1 COMMISSIONER GIRARD: I see that it  
2 goes further than that. You even say that you would  
3 like to be associated more with the physiatrists.  
4 Well, they should be the people that you would be  
5 working closely with, I would think, wouldn't that be?

6 MRS. BERND: Yes.

7 COMMISSIONER GIRARD: And you say here  
8 the occupational therapist would be pleased to be associated  
9 with psychiatrists and physiatrists in these teaching  
10 areas. That is in the medical education program that  
11 you are referring to?

12 MRS. BERND: Yes, in the schools it  
13 would be the physiatrist who would be doing the lecturing  
14 to the medical students, and we feel that a more compre-  
15 hensive program and mechanical experience in teaching  
16 settings, demonstrations and so forth, would help.

17 COMMISSIONER GIRARD: Somewhere else  
18 in this brief you are referring to the newer trend in  
19 the education of occupational therapists and physiothera-  
20 pists, instead of having the two having the same back-  
21 ground and taking four years for it, you are advocating  
22 that each one get a diploma at the end of three years.  
23 Am I correct in that?

24 MRS. BERND: Yes.

25 COMMISSIONER GIRARD: Do you feel that  
26 this should give physio and occupational therapists,  
27 I am always talking about the two, that this would be  
28 one way of speeding up the educational process, and  
29 therefore releasing more occupational therapists on  
30 the market, since there is a shortage? Is this why this



COMMISSIONER GILBERT: I see that it

goes further than that. You even say that you would

like to be associated more with the psychiatrists.

Well, they should be the people that you would be

working closely with, I would think, wouldn't that be?

MR. BRUND: Yes.

with psychiatrists and psychiatrists in these teaching

areas. That is in the medical education program that

you are referring to?

MR. BRUND: Yes, in the schools it

would be the psychiatrist who would be doing the lecturing

to the medical students, and we feel that a more compre-

hensive program and mechanical experience in teaching

settings, demonstrations and so forth, would help.

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1 was advocated?

2 MRS. BERND: This is one reason.

3 Another reason would be the proportion of graduates  
4 who would go into one profession or the other.

5 COMMISSIONER GIRARD: I see this is  
6 starting at the University of Montreal. They are going  
7 to start giving a diploma for each after the third year,  
8 but what was the experience in other places before you  
9 had this?

10 MRS. SMITH: Before combined training  
11 was instituted into the Canadian pattern of education  
12 of physio and occupational therapists, the proportion  
13 was about three occupational therapists to one physio-  
14 therapist.

15 One of the problems with combined  
16 training, from the viewpoint of supply of personnel, is  
17 that no one ever knows how many you are going to have.  
18 You don't know how many people are going to go into  
19 either physio or occupational therapy, so that in  
20 determining supply you have nothing to base it on, but  
21 prior to combined training the proportion in occupational  
22 therapy was greater than in physiotherapy.

23 Now, this does not suggest that it may  
24 be again. I mean, this is hind sight. What the future  
25 is you cannot tell, but another thing I feel is that  
26 across the country there is a trend towards the develop-  
27 ment of courses which will qualify therapists, either  
28 as physio or occupational therapists.

29 The trend to combined training is  
30 changing.



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be a gain. I mean, this is a bit slight. What the future

is you cannot tell, but another thing I feel is that

across the country there is a trend towards the develop-

ment of centres which will qualify therapists, either

as physio or occupational therapists.

The trend to combined training is

strong.



1 COMMISSIONER GIRARD: I see that you  
2 have the same problem as nurses have in recruiting  
3 male students. I think that some of the reasons for  
4 this problem seem to be similar also, and you state  
5 the question of salaries, that the salaries have to be  
6 high enough to attract a male student, who will get  
7 married and want to be able to support a wife and  
8 children.

9 Do you have any other reasons for the  
10 lack of male students in occupational therapy, because  
11 I think you could use them very well, the same as in  
12 nursing we could use a lot more male nurses?

13 MRS. SMITH: Up until very recently  
14 the universities didn't admit male students to the  
15 courses.

16 COMMISSIONER GIRARD: Why?

17 MRS. SMITH: They were excluded.

18 COMMISSIONER GIRARD: A question of  
19 men excluding men. I cannot understand it because  
20 universities are run mostly by men, we know that.  
21 But there is no other reason for that?

22 COMMISSIONER FIRESTONE: Women may be  
23 more competent.

24 MRS. SMITH: I think there has been a  
25 tradition that women look after the sick. I think this  
26 goes back into tradition, the same as in nursing, that  
27 woman's job is to look after the sick and the disabled.

28 Another thing is, going back to the  
29 Canadian Association of Occupational Therapy, which has  
30 established its own course in Kingston, and we have







1 admitted male students, and we have had a course  
2 running now for two years, the only course that has  
3 admitted male students, and we have graduated eight  
4 male students, so that there are men who are interested.

5 COMMISSIONER GIRARD: How many male  
6 occupational therapists would you have in Canada, do  
7 you have an idea?

8 MRS. SMITH: Yes, at the moment there  
9 are about five.

10 COMMISSIONER GIRARD: In all?

11 MRS. SMITH: Yes.

12 COMMISSIONER GIRARD: And how many do  
13 you think you could use, if you had them?

14 MRS. SMITH: I don't think it is  
15 limited. I feel that there are certainly specific areas  
16 to which the male would be more attracted than others,  
17 and I think particularly of perhaps the Department of  
18 Veterans' Affairs, where the great proportion of the  
19 patients are male, and also in the Workmen's Compensation  
20 centres, where you are dealing with industrial casualties,  
21 and also I believe in some of the community rehabilitation  
22 centres, where a large proportion of the patients are  
23 male, and are at the stage of treatment and rehabilitation  
24 where they are closer to their place of placement.

25 COMMISSIONER GIRARD: Would you also  
26 think it would give female patients a lift sometimes to  
27 be working with male occupational therapists? It would  
28 help their recovery?

29 MRS. SMITH: I think this is possibly  
30 so, but I think this is from the patient's point of view,





1 and we are now discussing it from the situations which  
2 would attract the male, and I don't know that the male  
3 would feel this, that he would want to work in the  
4 activities which are common to the female patient.

5 Another area where I think there is a  
6 great demand for male therapists is in the psychiatric  
7 services, and actually the majority, I guess all the  
8 male therapists that are employed in Canada, do work  
9 in psychiatric services.

10 COMMISSIONER BALTZAN: You referred to  
11 two schools of occupational therapy in the Province of  
12 Quebec. Are these separate, independent schools, or are  
13 they under other faculties of the university?

14 MISS DUNKIN: Both of these schools  
15 are set up in the Faculty of Medicine, one at McGill  
16 University and the other at the University of Montreal.

17 COMMISSIONER BALTZAN: Could you very  
18 briefly state just what the curriculum is? I don't  
19 want it in detail.

20 MISS DUNKIN: I can speak for McGill  
21 University. I think it would be better if Miss Forbes  
22 spoke for the University of Montreal.

23 At McGill one academic year is composed  
24 of five subjects, English, maths, biology, chemistry  
25 and physics. In their second year they take physiotherapy  
26 and occupational therapy and basic subjects. They study  
27 the conditions both physical and psychiatric they might  
28 meet in the course of treatment, and they are also  
29 required to study anatomy and psychology on the campus,  
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1 In the third year, if they are taking  
2 a diploma in occupational subjects they do more anatomy  
3 and physiology. If they continue to the degree they do  
4 a fourth year in which they acquire the balance of  
5 physiotherapy subjects, and a final year in which they  
6 do both professions, and during these two years they  
7 carry a complement of academic subjects.

8 COMMISSIONER BALTZAN: It seems to me  
9 that the therapeutic portion only comes in towards the  
10 end.

11 MISS DUNKIN: I mentioned the thera-  
12 peutic aspect from the second year on. They only have  
13 one academic year.

14 COMMISSIONER BALTZAN: So it carries  
15 all the way through?

16 MISS DUNKIN: Yes, plus hospital  
17 experience.

18 COMMISSIONER BALTZAN: Would you give  
19 us an outline of the day's work of an active occupational  
20 therapist?

21 MISS DUNKIN: Within a university?

22 COMMISSIONER BALTZAN: No, out, as a  
23 graduate and occupied?

24 MISS DUNKIN: I would like to turn this  
25 question to someone who is in the field at the moment.

26 MRS. BERND: An active graduate occupa-  
27 tional therapist would be working in a hospital or  
28 rehabilitation centre, or a related institute or psychia-  
29 tric set-up.

30 In a full day she would have a caseload



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1 of patients who were her responsibility. She would be  
2 working under the supervision of a qualified occupational  
3 therapy supervisor, unless she happens to be in one of  
4 the many settings where we do not have enough therapists  
5 to provide proper senior supervision, and we find junior  
6 therapists taking responsibilities that they are not  
7 really ready for yet.

2  
8 She would work with the patients them-  
9 selves, be in contact with the other professional  
10 personnel in the hospital. She might be might be  
11 attending conferences to deal with the patient's progress.  
12 She is responsible for the program of her patients,  
13 which might involve some preparation of work for that  
14 patient.

15 COMMISSIONER BALTZAN: What does she do  
16 for the patient outside of giving advice and recommenda-  
17 tions, say, in relation to occupation or adaptation  
18 under the circumstances of disability for the kind of  
19 work that the patient may be able to do? Does she  
20 treat the patient physically? Does the occupational  
21 therapist treat the patient physically?

22 MRS. BERND: Do you mean does she handle  
23 the patient physically? Touch him physically?

24 COMMISSIONER BALTZAN: Yes.

25 MRS. BERND: This would be at a minimum  
26 in this profession. It is more a matter of stimulating  
27 and encouraging the patient to do things for himself.  
28 To enable him to become more efficient in dressing, and  
29 his ambulatory progress.

30 The program varies tremendously from



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1 person to person in occupational therapy.

2 COMMISSIONER BALTZAN: Would you say

3 then that the occupational therapist is a branch of

4 the whole panorama of rehabilitation medicine?

5 MRS. BERND: Yes, I would.

6 COMMISSIONER BALTZAN: It is a segment?

7 MRS. BERND: Yes.

8 COMMISSIONER BALTZAN: You say on page

9 2:

10 "It is recommended that the desirable

11 ratio of occupational therapists to

12 in-patients is 1 in 70."

13 You mean in-patients in hospital?

14 MRS. BERND: Yes.

15 COMMISSIONER BALTZAN: Is that realistic?

16 Does a general hospital require that proportion, or are

17 you referring here to a rehabilitation centre?

18 MRS. BERND: This was a composite of

19 the ratios given in the table as an average which was

20 worked out. The recommended ratios of therapists per

21 bed, I think, are in the table on page 6.

22 COMMISSIONER BALTZAN: If that whole

23 program was carried through, then you would require so

24 many occupational therapists, so many physiotherapists,

25 and so many psychiatrists?

26 MRS. BERND: I think you could work it

27 out that way, and the number would depend on the actual

28 field you were working in.

29 COMMISSIONER BALTZAN: Do you come

30 under the aegis of the psychiatrist, or the physical





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COMMISSIONER BARTON: Do you come

under the realm of the psychiatrist, or the physical



1 medicine people?

2 DR. GOLDBLOOM: Yes sir, that is  
3 largely true. As a sister profession the occupational  
4 therapist works with the medical profession, and to  
5 some extent under his direction, but also has some  
6 independence of action in prescribing the specific  
7 occupational therapy which the patient may require.

8 I think that you might say that the  
9 medical profession is developing a growing respect for,  
10 and a growing knowledge of, our sister professions,  
11 and that we treat their opinions with respect, and feel  
12 that in some situations that they are better qualified  
13 than we to set out the specific details of a program in  
14 their field.

15 COMMISSIONER BALTZAN: Eventually, do  
16 graduate occupational therapists sometimes start out on  
17 their own, and receive patients on their own?

18 MRS. BERND: No, occupational therapists  
19 are not engaged in private practice.

20 COMMISSIONER BALTZAN: In what way do  
21 you come to the assistance of the psychiatric patient,  
22 also in the form of reinstating him into a field of  
23 occupation, or do you do any psychiatric treatment or  
24 education of the psychiatric patient?

25 MRS. QUASTEL: I think we can answer  
26 yes to all three aspects. We both come into the matter  
27 of reinstating the psychiatric patient into the community,  
28 and assisting him in the maximum use of his abilities.

29 As well, we participate in the treatment  
30 of the patient while he is in a hospital.







1                                    COMMISSIONER BALTZAN: Thank you very  
2 much. You were very good with these answers. I would  
3 just like, for my own clarification in order to be  
4 properly oriented; we have the matter of physiatrists,  
5 occupational therapists, and physiotherapists, and I  
6 would like, if anybody here can tell me, where does the  
7 university degree course of physical education come in  
8 under that whole scheme? Does anybody know, or do you  
9 care to answer?

10                                MISS DUNKIN: This is a distinct course,  
11 and it does not have any medical connotation whatsoever,  
12 to the best of my knowledge. I don't think it would  
13 bar anyone going into service of the disabled, but they  
14 would have to have extra training in order to understand  
15 their patients.

16                                COMMISSIONER BALTZAN: They look after  
17 the healthy?

18                                MISS DUNKIN: As a rule, yes.

19                                COMMISSIONER FIRESTONE: You were  
20 telling us that the greatest shortage of occupational  
21 therapists is in the psychiatric field. Why?

22                                MRS. SMITH: I think there are many  
23 reasons for this. I believe, and my statistics are not  
24 here, but I believe that there are more psychiatric  
25 patients, or more psychiatric beds, than any other  
26 disability, and the history of occupational therapy goes  
27 back to its beginnings in the treatment of mental illnesses,  
28 and the development in the physical field, as in many  
29 other para-medical services, has been more a come-lately  
30 development. I think that the psychiatric patient



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back to the beginning in the treatment of mental illness

and the development of the physical field, as it were,

of the post-medical services, has been more a consequence



1 without employment becomes a more ill person, and that  
2 he must have a structured program, and an opportunity  
3 to engage in realistic activities. Otherwise he sits  
4 in a corner and becomes more ill.

5 Now, this fact is not as evident in  
6 the physical disabilities as it is in the psychiatric.

PB/dpw

7 DR. GOLDBLOOM: Mr. Chairman, I would  
8 like to expand that answer. I think that one of the  
9 chief reasons for occupational therapy lacking in psychia-  
10 tric institutions lies in the problem which exists in  
11 psychiatric institutions at the present time, and which  
12 we are only beginning to work on, and that is this  
13 being considered as a custodial place and that active  
14 rehabilitation of the psychiatric patient is something  
15 that we are only beginning to work on.

16 I think with the partnership of the  
17 sister profession, of the medical profession, will  
18 contribute a great deal towards this movement.

19 COMMISSIONER FIRESTONE: If you could  
20 continue along that line, sir, how does occupational  
21 service in the psychiatric field work together with the  
22 doctor? Are they working as a team and if so, how?  
23 Does the doctor prescribe attendance by occupational  
24 therapists in this field?

25 DR. GOLDBLOOM: Yes sir, the doctor  
26 prescribes, and the conduct of any person with a patient  
27 in a psychiatric ward or institution has a therapeutic  
28 effect, and anyone who works in such an institution is  
29 obligated to participate in conferences which include  
30 members of all the disciplines working with the patients,







1 and the case of each patient should, ideally, come up  
2 for review so that each person representing each disci-  
3 pline working with that patient is sure of what the  
4 total program is for that patient and sure that their  
5 contribution is a positive one and working towards the  
6 rehabilitation of the patient.

7 COMMISSIONER FIRESTONE: What would be  
8 the effect of the present trend towards treating more  
9 mentally disturbed patients in general hospitals as far  
10 as increasing the use of occupational therapists in this  
11 field is concerned?

12 MRS. SMITH: There is a very definite  
13 trend to the establishment of psychiatric units within  
14 general hospitals and, another thing here is that the  
15 ratio of occupational therapists is much higher in this  
16 area in that in the small units which may operate from  
17 28 to 40 patients with all the other services or a multi-  
18 tude of other services, so there are fewer  
19 occupational therapists needed.

20 There is going to be great development  
21 in this area and it is in this field particularly, in  
22 psychiatry, that we feel the need for some experienced  
23 people because you have a ratio of one occupational  
24 therapist to a service.

25 If you don't have an experienced person  
26 in this area you have a much less satisfactory program  
27 because she has no one else to go to except her physician,  
28 but there are no other occupational therapists with whom  
29 she can work.

30 COMMISSIONER FIRESTONE: This question







1 perhaps is addressed to you, Dr. Goldbloom; is there  
2 any difficulty with the psychiatrists using occupational  
3 therapists in the sense that they may feel that these  
4 people may not be as helpful to the patient. Is there  
5 anything in the relationship between the doctor and  
6 the occupational therapist that prevents the increasing  
7 use, or is there something wrong with the system? What  
8 is the reason?

9 DR. GOLDBLOOM: Well, Mr. Chairman, the  
10 reason, if there is any, is simply numerical. I think  
11 in this brief of the occupational therapists reference  
12 is made to the need for education of medical students  
13 to make them more aware of the functions and values of  
14 occupational therapy, but at the same time I think that  
15 we experience relatively little difficulty with the  
16 utilization of such services as are available and could  
17 make use of a great deal more.

18 COMMISSIONER BALTZAN: I might direct  
19 my question to you, Dr. Goldbloom; the use of occupational  
20 therapists be given to medical students both in theoretical  
21 and practical settings. My question is: is that not  
22 already part of the curriculum in the rehabilitation  
23 departments of medical centres and hospitals?

24 DR. GOLDBLOOM: This is not universally  
25 so. There may be a single demonstration, a single  
26 contact which informs the medical student that services  
27 such as occupational therapy exist.

28 I am not even certain if it is available  
29 in all medical schools. Certainly in the hospital  
30 settings we try as much as possible to make the interns





1 aware of the full range of services available and to  
2 indoctrinate them in the use of this service, but the  
3 medical school - this has not been developed to an  
4 adequate degree.

5 COMMISSIONER BALTZAN: Are they not in  
6 some cases actually directed and instructed, certainly  
7 where there is a fairly elaborate rehabilitation depart-  
8 ment?

9 DR. GOLDBLOOM: Yes sir.

10 COMMISSIONER FIRESTONE: Mrs. Bernd,  
11 on page 11 you recommend, and I quote:

12 "That the existing faculty of medicine  
13 establish and maintain separate courses  
14 of physiotherapy and occupational  
15 therapy."

16 Mrs. Bernd, if such courses were  
17 established would you feel there would be a sufficient  
18 number of applicants and students to make use of those  
19 additional facilities created?

20 MRS. BERND: I feel there would be,  
21 from the experience I have had in the field.

22 COMMISSIONER FIRESTONE: Would you say  
23 these existing facilities are inadequate and that people  
24 are being turned down?

25 MISS DUNKIN: There are two factors in  
26 that recommendation; one is for more schools and the  
27 other is for separate courses. I feel most strongly  
28 for the one of separate courses which could very well  
29 acquire more applicants since the basic requirement  
30 under it could be different.





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1 MRS. SMITH: We have certainly noticed  
2 and there is evidence to support it where a school has  
3 developed you also get the development of service  
4 experience in that area. I think this is another very  
5 salient point. If there is no school you don't get the  
6 same development of this type of thing.

7 As new schools have developed across  
8 the country we are having people attracted to these  
9 areas.

10 COMMISSIONER FIRESTONE: That is a very  
11 good point of view. Thank you very much. Mrs. Bernd,  
12 on page 12 you recommend, and I quote:

13 "That greater publicity within high  
14 schools in the community at large be  
15 initiated", to attract young people  
16 into occupational therapy courses. Who should do this?

17 MRS. BERND: I feel the bulk of the  
18 responsibility lies with the professional Association  
19 of Occupational Therapists. It could be also done  
20 through educational facilities and so forth.

21 COMMISSIONER FIRESTONE: Is there any  
22 encouragement you would expect the Government to provide,  
23 or assistance?

24 MRS. SMITH: In the past year or so the  
25 Department of Health and Welfare in Ottawa has prepared  
26 a great many documents on career opportunities for the  
27 various professional groups and we have been very  
28 grateful for these.

29 The professional associations are small  
30 and are not endowed with much wealth. We do have the



and there is evidence to support it where a school has  
developed you also get the development of services  
experience in that area. I think this is another very  
salient point. If there is no school you don't get the  
same development of this type of thing.  
As new schools have developed across  
the country we are having people attached to them

COMMISSIONER RICHMOND: That is a very

good point of view. Thank you very much. Mrs. Bland,  
on page 12 you recommend, and I quote:  
"That greater efficiency within high  
schools in the community at large be  
initiated, to attract young people  
into occupational therapy courses. Who should do this?  
Mrs. Bland: I feel the bulk of the  
responsibility lies with the provincial Association  
of Occupational Therapists. It could be also done  
through educational facilities and so forth.

COMMISSIONER RICHMOND: Is there any

encouragement you would expect the Government to provide,  
or assistance?

Mrs. Smith: In the past year or so the

various professional groups and we have been very  
careful for these.

and are not endowed with much wealth. We do have this





1 contact by which we can see that this information which  
2 is given to us is sent out to the appropriate areas,  
3 and this we have done. We have also assisted in the  
4 writing of the material and we would hope that the  
5 Department of Health and Welfare would continue to make  
6 this material available, and that we would assume the  
7 disposition of it.

8 COMMISSIONER FIRESTONE: You want more  
9 educational literature?

10 MRS. SMITH: That is right.

11 COMMISSIONER FIRESTONE: From the  
12 Department of National Health and Welfare?

13 MRS. SMITH: Yes.

14 DR. GOLDBLOOM: One thing we have  
15 encouraged, at least in the local area in Montreal, is  
16 group tours of hospitals, bringing students to the  
17 hospitals and showing them the activities which go on  
18 there. This has been very successful, at least, in  
19 terms of interest shown. It has been very encouraging.

20 COMMISSIONER FIRESTONE: When you say  
21 "we", who do you mean, sir?

22 DR. GOLDBLOOM: The administration of  
23 hospitals are chiefly responsible for this, but any  
24 individual person on the staff who has an opportunity  
25 to invite such a group only has to apply to the medical  
26 administrator and permission is granted and arrangements  
27 are made.

28 One has to respect the work of the  
29 hospital and the isolation techniques and the sterility  
30 and so on. This has to be planned rather carefully.



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and this we have done. We have also assisted in the

writing of the material and we would hope that the

Department of Health and Welfare would continue to make

this material available, and that we would receive the

organization of it.

COMMISSIONER FINESTONE: You want more

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hospital and the isolation techniques and the staff

and so on. This has to be planned rather carefully.



1 Taking a good many people into the hospital in a group  
2 is something which can't be done casually, but the  
3 hospitals are trying to organize these in a very effective  
4 way.

5 COMMISSIONER FIRESTONE: In other words,  
6 you would therefore encourage hospitals to do more of  
7 this type of public education?

8 DR. GOLDBLOOM: Yes.

9 COMMISSIONER FIRESTONE: Thank you.  
10 My last question, Mrs. Bernd, refers to your recommenda-  
11 tion in paragraph 6 on page 13 where you recommend:

2 12 "That the number and scope of these  
13 bursaries be increased to encourage  
14 students to enter this field and to  
15 continue studies on a post-graduate  
16 level."

17 What do you have in mind, and what  
18 amount?

19 MRS. SMITH: Do you want me to speak  
20 to that?

21 Well, there are very few bursaries  
22 available for students who are not entering degree  
23 courses and this is where occupational therapy suffers.  
24 Bursaries are made available but they are limited by  
25 the course which the student is going to take. We  
26 feel that a great many students with a certain amount  
27 of funds, sometimes a scholarship student has not been able  
28 to take a university course without some assistance.

29 I think it is difficult to say what  
30 the amount should be. We know it costs \$2,000 a year





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What do you have in mind, and what

MRS. SMITH: Do you want me to agree

to that?

Well, there are very few barriers

available for students who are not entering degree

courses and this is where occupational therapy suffers.

Barriers are made available but they are limited by

the course which the student is going to take. We

feel that a great many students with a certain amount

of funds, sometimes a scholarship, student has not been able

to take a university course without some assistance.

I think it is difficult to say what

the amount should be. We know it costs \$2,000 a year



1 for a girl to be educated as an occupational therapist.  
2 She may well have a proportion of that money herself.  
3 We wouldn't expect the whole of the \$2,000 would be  
4 needed, but I think the limiting effect of these bursaries  
5 that are available, many of them are - not many who can  
6 have them.

7 I had an example the other day of a  
8 girl who called and wanted assistance to take up occupa-  
9 tional therapy. She could have qualified for a bursary  
10 if she was going to take a pass arts course, which is  
11 the same length of time, three years, but she couldn't  
12 qualify because it wasn't a degree course.

13 COMMISSIONER FIRESTONE: If such a  
14 scheme were introduced as you recommend a certain amount  
15 would have to be attached to the bursary. What would  
16 you recommend, \$500, \$1,000, \$1,500?

17 MRS. SMITH: I would say probably  
18 \$1,000.

19 COMMISSIONER FIRESTONE: Would you  
20 increase this amount for the graduate level?

21 MRS. SMITH: Yes, I think it would have  
22 to be increased because we find a great many girls are  
23 interested in going on into post-graduate work but  
24 their occupational therapy salaries are such that they  
25 are not able to accumulate sufficient funds, and in  
26 addition to that they lose income during the two-year  
27 course or whatever they take.

28 Another thing; this bursary system varies  
29 greatly across the Dominion because of provincial,  
30 federal agreements. Some provinces will grant to



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that are available, many of them are - not many who can

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girl who called and wanted assistance to take up occupa-

tional therapy. She could have qualified for a primary

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1 undergraduate students. Some will grant to graduate  
2 students. I know there have been a great many of them  
3 that carry return-in-service clauses so that some  
4 provinces send them to Ontario or Quebec for training  
5 on the understanding that they will go back to their  
6 own province and work out their term agreement in  
7 return service.

8 The pattern is not the same across the  
9 country and this causes some confusion on the part of  
10 the students. There is a pamphlet which is put out by  
11 the Department of Health and Welfare and it says if you  
12 wish bursary assistance grants apply to your Provincial  
13 Department of Health.

14 In some provinces the bursary is then  
15 forthcoming, but in others it isn't. The students read  
16 this and assume there is a bursary everywhere, and this  
17 is not so.

18 COMMISSIONER FIRESTONE: What would you  
19 have in mind for graduate students' scholarship, \$1,500,  
20 \$2,000?

21 MRS. SMITH: I would think this would  
22 depend entirely on the course which she was going to  
23 enter. As you will note, on the grant system for the  
24 graduate you put in what you require and it is either  
25 approved or not approved.

26 COMMISSIONER FIRESTONE: I appreciate  
27 that, but we are looking for some guide.

28 MRS. SMITH: In money?

29 COMMISSIONER FIRESTONE: In money terms  
30 since we are to make recommendations that will involve

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students. I think there have been a great many of them  
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the students. There is a proposal which is put out by  
the Department of Health and Welfare and it says if you  
want university assistance grants apply to your Province.  
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In some provinces the priority is then  
postponed, but in others it isn't. The students need  
this and assume there is a priority everywhere, and this  
is not so.

COMMISSIONER WATSON: What would you  
have in mind for graduate students' scholarships, \$1,000,  
\$2,000?

MRS. SMITH: I would think this would  
depend entirely on the course which she was going to  
attend, as you will note, on the grant system for the  
graduate you put in what your needs are and in other  
words of that nature.

COMMISSIONER WATSON: I agree with  
that, but we are looking for some grant.

MRS. SMITH: In my opinion  
COMMISSIONER WATSON: In my opinion  
I think we are to make recommendations that will involve



1 money, or not make recommendations, as the case may be.  
2 We would like some ideas from you; what would be your  
3 advice?

4 MRS. SMITH: I would think the graduate  
5 should be \$1,500 to \$2,000 a year.

6 COMMISSIONER FIRESTONE: Would you like  
7 to see these scholarships or bursaries tied in terms of  
8 having to go back to certain places and spending certain  
9 years in these institutions or these localities?

10 MRS. SMITH: I would like to see that  
11 tied to the fact the students go back to Canada. We  
12 find a great many of them - there are no post-graduate  
13 courses across the country. A great many people are  
14 prone to go to the United States where there are many  
15 of them.

16 When they get down there the salaries  
17 in the United States are very attractive and they are  
18 prone not to come back.

19 COMMISSIONER FIRESTONE: Would you  
20 attach a condition within Canada?

21 MRS. SMITH: Within Canada.

22 COMMISSIONER FIRESTONE: Perhaps I  
23 didn't make myself clear. Would you want the scholar-  
24 ship to say whether a person should stay in this part  
25 of Canada or in that part of Canada, not going to the  
26 States, but in Canada, within Canada?

27 MRS. SMITH: I think it would depend on  
28 from what level the bursary was granted. As it is now if  
29 it is granted by the provinces you are committed to that  
30 province.



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13 of them.

14 When they get down there the salaries  
15 in the United States are very attractive and they are  
16 going not to come back.

17 COMMISSIONER FIRSTONE: Would you  
18 suggest a condition within Canada?

19 MRS. SMITH: Within Canada.

20 COMMISSIONER FIRSTONE: Perhaps I  
21 shall make myself clear. Would you want the scholar-  
22 ship to say whether a person should stay in this, not  
23 of Canada or in that part of Canada, not going to the  
24 States, but in Canada, within Canada?

25 MRS. SMITH: I think it would depend on  
26 from what level the money was granted. As it is now it  
27 is granted by the provinces you are committed to that



1 If the bursary came from federal funds  
2 then I would think it could be used anywhere in Canada.

3 COMMISSIONER FIRESTONE: My last  
4 question is: have you any suggestions as to how many  
5 bursaries or scholarships you think should be awarded a  
6 year to occupational therapists in Canada as a whole,  
7 20, 25, 30?

8 MRS. SMITH: No, I think perhaps it  
9 would be less at the present time because of our great  
10 lack of therapists and the number of people who would  
11 possibly want to do it or would have the qualifications  
12 to do it.

13 COMMISSIONER FIRESTONE: I am not  
14 referring to graduates. I am referring to students.  
15 You want to encourage more young people to enter the  
16 field. Financial barriers would be one factor. All  
17 right, how do we overcome it? Can you suggest a figure  
18 you would consider desirable and would help fill the  
19 gap?

20 MRS. SMITH: Are you asking this for  
21 all Canada?

22 COMMISSIONER FIRESTONE: For all of  
23 Canada.

24 MRS. SMITH: Or the province - for all  
25 of Canada?

26 COMMISSIONER FIRESTONE: If you want to  
27 give it for Quebec you are welcome to. We can always  
28 work out the arithmetic.

29 MRS. SMITH: I wouldn't speak for  
30 Quebec. I do not think we are prepared to answer this







1 at the present time. I think we would have to make  
2 some investigation as to the students that are presently  
3 enrolled who have found it very difficult to find  
4 financial support. I think this could be easily found  
5 out from the various schools right across the country  
6 and we could give you that answer and it would be more  
7 meaningful than a snap judgment at the moment.

8 MRS. BERND: Yes, we could do that.

9 COMMISSIONER FIRESTONE: That is an  
10 excellent suggestion. We would be very grateful to take  
11 you up on it. If you could send in a written communica-  
12 tion to the Secretary noting the number of scholarships  
13 at the undergraduate and graduate level which you would  
14 recommend, (a) to the Province of Quebec and (b) to the  
15 rest of Canada, if that is appropriate.

16 MRS. SMITH: This would get into our  
17 submission which takes place later, of the Canadian  
18 Association.

19 COMMISSIONER FIRESTONE: We would be  
20 happy to have the Canadian proposal in Toronto but if  
21 we could have a written communication as far as the  
22 number in Quebec is concerned from you, Mrs. Bernd.

23 MRS. BERND: We will do that.

24 COMMISSIONER FIRESTONE: Thank you  
25 very much, ladies. You have been very helpful, and  
26 Doctor.

27 THE ACTING CHAIRMAN: I want to turn  
28 for a moment to Appendix 3. Maybe I don't understand  
29 it. If I understood it correctly you recruited into  
30 the profession in five years from 1957 to 1961 inclusive





1 146 occupational therapists in the Province of Quebec  
2 and you lost 91 during that period. Is marriage the  
3 cause?

4 MRS. SMITH: Oh, yes.

5 THE ACTING CHAIRMAN: Is there a tendency,  
6 or have you gone on long enough for the married women  
7 to return to the profession after a certain time?

/PmcH/dpw 8 MRS. BERND: This trend is just becoming  
9 more noticeable now that the married women are tending  
10 to go back to work. Their children are getting to the  
11 age where they feel they can leave them and spend some  
12 time, if not full-time, working.

13 THE ACTING CHAIRMAN: In other words,  
14 the profession is young enough that you have not had  
15 too much experience in that line to date?

16 MRS. BERND: That is right.

17 THE ACTING CHAIRMAN: There is one  
18 other point I would like to comment on; out of your  
19 recruitment of 146, 72 were trained in foreign schools  
20 and of the total complement that you have today more  
21 than half are from foreign schools. You cannot count on  
22 that continuing, can you?

23 MRS. BERND: No, I think that is a very  
24 fluctuating and nebulous proportion really. We have no  
25 way of knowing whether this will continue, increase or  
26 decrease.

27 THE ACTING CHAIRMAN: Would that be  
28 largely European immigration?

29 MRS. BERND: I think it is mostly U.K.  
30 therapists and we would like to be in a position where we







1 feel we can fill our own needs from our own trained  
2 therapists rather than depending on immigration because  
3 it is so unsure.

4 THE ACTING CHAIRMAN: It points up the  
5 problem that it is more acute from the point of view of  
6 training Canadian occupational therapists than the  
7 figures would show?

8 MRS. BERND: That is right.

9 THE ACTING CHAIRMAN: Thank you very  
10 much on behalf of the Commission. I want to congratulate  
11 you on the brief that you have prepared, not only have  
12 you presented your views and your conclusions and your  
13 recommendations clearly and concisely but they have been  
14 well founded. We appreciate the trouble that you and  
15 your associates must have gone to in preparing this  
16 brief and we are very grateful to you for being here  
17 this morning. Thank you very much.

18 We will now adjourn until 2 o'clock.

19  
20 --- Luncheon adjournment.  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30







lcH/dpw

1 --- On resuming at 2 p.m.

2 THE ACTING CHAIRMAN: Ladies and  
3 gentlemen, we will proceed with the brief of the  
4 Victorian Order of Nurses for the Province of Quebec  
5 and this brief will be known as Exhibit 218.

6  
7 --- EXHIBIT NO. 218: Submission of the Victorian Order  
8 of Nurses for the Province of  
9 Quebec.

10 SUBMISSION OF THE VICTORIAN ORDER OF NURSES  
11 FOR THE PROVINCE OF QUEBEC.

12 Appearances: Mr. W.B. Earl  
13 Mr. G.P. Keeping  
14 Miss Lorette Roy  
15 Miss D. Small

16 THE ACTING CHAIRMAN: Mr. Keeping?

17 MR. KEEPING: I think Mr. Earl would  
18 like to introduce the representatives here.

19 MR. EARL: Mr. Chairman, on my extreme  
20 left is Miss Small, District Director for the Greater  
21 Montreal Branch and next to her is Miss Roy, Regional  
22 Director for the Province of Quebec. Mr. George Keeping,  
23 Honorary President for the Province of Quebec and Vice-  
24 President of the Greater Montreal Branch.

25 THE ACTING CHAIRMAN: Mr. Keeping, would  
26 you proceed with dealing with your summary and your  
27 recommendations?

28 MR. KEEPING: Mr. Chairman, the Victorian  
29 Order of Nurses for Canada was founded in 1897 and in  
30 1898 Montreal organized the first branch in the Province  
of Quebec. The provincial organization is confirmed





1 under a provincial charter as a non-profit organization  
2 as a first step towards the co-ordination of the services  
3 at the provincial level. The provincial organization  
4 does not, however, at the present time, exercise any  
5 executive function over the branches but it has been  
6 used as the agency through which the Victorian Order  
7 operating in Quebec has made submissions to the Provin-  
8 cial Government and other authorities.

9                   The Victorian Order of Nurses in Quebec  
10 are constituted in areas with a total population of  
11 2,200,000 people. These areas include Montreal and  
12 surrounding communities within a radius of 33 miles,  
13 Sherbrooke, Hull, and Rouen Noranda; a branch at Lachine,  
14 a branch at Ville la Salle, a branch at Pointe Claire,  
15 at Ste. Anne de Bellevue, one at Rosemere, one at Hull,  
16 one at Sherbrooke and one at Rouen Noranda.

17                   The greater metropolitan branch, Montreal  
18 branch, which includes the City of Montreal, and a number  
19 of surrounding municipalities, does not include the  
20 whole of the island of Montreal, as I indicated.

21                   The Greater Montreal Branch does not  
22 provide service to the French-speaking population;  
23 service to that sector being handled by the Société des  
24 Infirmières Visiteuses.

25                   In 1960 32,533 visits were made to  
26 13,462 patients. The majority of visits are made to  
27 the chronically ill and those in the old-age group,  
28 categories calling for special skills in rehabilitation  
29 nursing.

30                   Considerable progress has been made in







1 recent years in providing continuity of care from the  
2 hospital to the home by means of liaison programs with  
3 hospitals.

4 One of the most interesting developments  
5 in recent years has been the development of hospital  
6 liaison programs. In 1955 a pilot referral plan was  
7 inaugurated by the Victorian Order in conjunction with  
8 the Montreal General Hospital. This is a plan of having  
9 a Victorian Order nurses placed in the hospital and is  
10 able, therefore, to obtain all the details of those  
11 persons being dismissed by the hospital or those who are  
12 in need of additional care in the home.

13 This hospital referral program is a  
14 major step forward in providing continuity of care  
15 between the hospitals and the home.

16 From the start this program with the  
17 Montreal General was a great success and it was evaluated  
18 by a committee in which the Department of National  
19 Health and Welfare partook and it was found to be a very  
20 worthwhile undertaking.

21 Some few years later the Royal Victorian  
22 Hospital inaugurated a similar plan with the Victorian  
23 Order of Nurses and more recently still, less than a  
24 year ago, a plan was started with St. Mary's Hospital.

25 This is only on a part-time basis but  
26 it is developing along the lines of the other two  
27 programs which have been in existence considerably  
28 longer.

29 As a matter of interest, in 1961, 829  
30 new patients were referred to the Victorian Order from







1 the Montreal General Hospital and in excess of 1,200  
2 from the Royal Victoria Hospital.

3 In our opinion these hospital referral  
4 programs are an extremely important area of our service.

5 The homemaker also provides a service  
6 in addition to nursing care in the home. It conducts  
7 a number of pre-natal education classes to expectant  
8 mothers and these are carried out both in the Montreal  
9 area and in Hull.

10 In 1960 approximately 1,000 expectant  
11 mothers; I might say that the fathers come into it  
12 sometimes too, attended the Victorian Order of Nurses'  
13 classes. In addition the V.O.N. does some part-time  
14 industrial nursing service for commercial organizations.

15 At the present time there are only two  
16 organizations in the Montreal area that are availing  
17 themselves of the V.O.N. service. In one area, in Rose-  
18 mere, where Mr. Earl is President, the V.O.N. also does  
19 the school nursing. The V.O.N. also does a considerable  
20 amount in the educational field both at the undergraduate  
21 level and the post-graduate level.

22 The V.O.N. participates by providing  
23 field experience for nurses taking post-graduate courses  
24 in public health nursing both at McGill and the University  
25 of Montreal.

26 It provides participation experience  
27 for undergraduates at the hospital schools of nursing  
28 and it also provides observation experience for third-  
29 year medical students.

30 We believe, in the interests of the





1 community at large, that the use of visiting nurse  
2 services should be further developed. We believe that  
3 there are considerable areas in the province where  
4 visiting nursing service is not now readily available  
5 and where provision of services should immediately be  
6 considered.

7 In our submission the areas are listed  
8 and I can mention a few of them only. To the best of  
9 my knowledge there is no visiting service in Granby,  
10 Drummondville, the Seven Islands area, the Lac St. John  
11 area. It may be of interest to you to know that only  
12 very recently we received an enquiry from the Seven  
13 Islands area asking us whether we could assist in provi-  
14 ding services in the area.

15 Miss Roy paid a visit a short time ago  
16 to investigate the situation there. We believe that  
17 there is room for expansion territorially of the services  
18 in the Province of Quebec and we believe it is desirable.

19 We also believe that in the interests  
20 of economy and fuller expansion, that the scope of visiting  
21 nurse services is desirable. We believe some of the  
22 areas of expansion to which particular attention should  
23 be paid are expansion of hospital liaison programs to  
24 which I have already referred. I think there is little  
25 doubt that these hospital liaison programs result in  
26 considerably earlier discharge from hospital than would  
27 otherwise be possible.

28 I believe also that they are instrumental  
29 in cutting down substantially on re-admissions to hospital.

30 It is not possible to give you actual



community at large, that the use of visiting nurse services should be further developed. We believe that

there are considerable areas in the Province where visiting nursing services is not now readily available and where creation of services should immediately be

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ding services in the area.

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of economy and further expansion, that the scope of visiting

nurse services is desirable. We believe some of the

areas of expansion to which particular attention should

be paid are expansion of hospital liaison programs to

which I have already referred. I think there is a

need for these hospital liaison programs in

order to avoid earlier discharge from hospital than would

otherwise be possible.

I believe also that they are important

in relation to the expansion of hospital

it is not possible to give you a



1 figures or cite statistics on this but there was a  
2 comprehensive study made some years ago and when I say  
3 some years ago, it is recently, five or six years ago,  
4 in the State of New York, where there was a pilot project  
5 done in conjunction with the Blue Cross. The result of  
6 the studies showed that the inclusion of visiting nurse  
7 services in hospital benefits provided by the Blue Cross  
8 resulted in a substantial reduction in the length of  
9 stay in hospital and also reduced re-admissions by  
10 providing additional very much needed hospital beds.

11 Another area in which we think the  
12 scope of visiting nursing services could be beneficially  
13 expanded is in participation with home care plans.  
14 Frequently we find that individuals have to be retained  
15 in hospital because there are not present in the home  
16 the necessary homemaking facilities and unless there are  
17 the necessary homemaking facilities then, of course, the  
18 patient cannot stay in the home.

19 We believe that where homemaking facilities  
20 are available then a great many additional patients  
21 could be released from hospital.

22 The Victorian Order, or any visiting  
23 nursing service, would be able to co-operate with these  
24 plans and, therefore, enable that patient to be cared  
25 for in his home.

26 We also believe there is a role to be  
27 played by visiting nursing services in rehabilitation  
28 as a nursing consultant service in institutions providing  
29 low-cost bed care such as nursing homes for the chronically  
30 ill and homes for the aged.

...on this point...

...live on...  
...there was a...  
...The result of...  
...the institution of visiting nurses...  
...the Blue Cross...  
...in the region of...  
...also reduced re-admission...  
...very much needed hospital beds...  
...in which we think the

...could be beneficially...  
...in home care plans...  
...be retained...  
...in the home...  
...and unless there are...  
...of course, the...  
...to the home.

...we believe that where home-making facilities...  
...and available from a great many additional patients...  
...could be retained from hospital.

...The Visiting Nurse, or any visiting...  
...service, would be able to co-operate with these...  
...and, therefore, would be able to be carried...  
...for the home.

...we believe there is a need to...  
...visiting nursing service in institutions...  
...institutions...  
...for the home...  
...for the home...





1 If it is thought that there is need for  
2 further low-cost institutions it is believed that visiting  
3 nursing services can play a part in these institutions  
4 in a consulting capacity.

2 5 The Victorian Order with its hospital  
6 experience and high reputation in the field is ideally  
7 suited and would want to assist and take part in any  
8 future expansion of visiting nursing services in Quebec.

9 As to personnel, the ten branches of  
10 the V.O.N. in Quebec employ 82 registered nurses and two  
11 nursing assistants; of the registered nurses, 44 have  
12 special training in public health nursing. This is an  
13 area in which we have been recognized the most since the  
14 early days.

15 It is important for the V.O.N. to have  
16 public health training as well as the qualification as  
17 a registered nurse.

18 I should also point out that where a  
19 facility in both languages is required, in those areas  
20 where facility in both languages is required, the V.O.N.  
21 are bilingual. There is no doubt that any sudden or  
22 substantial expansion of service would present a problem  
23 in providing the number of adequately qualified personnel.

24 We also feel that in future development  
25 of visiting nurse services it is very important that the  
26 attitude of mind and personal sense of service such as  
27 that prevailing among the V.O.N. nurses be preserved.

28 We feel that the status of the V.O.N.  
29 as a volunteer agency has been a beneficial one and  
30 should be retained in the future as a volunteer agency.





1 Our branch of the V.O.N. is under the  
2 overall management of a board composed of public-spirited  
3 citizens and these boards are responsible for the finan-  
4 cing of the service as well as provision of the services.

5 In addition to the members of the  
6 various boards, many other citizens are involved in  
7 maintaining of the services, not only in fund raising  
8 activities but also in the day-to-day work of their  
9 branches.

10 A noteworthy example I might quote in  
11 the Montreal branch; a committee of ladies of the  
12 Women's Auxiliary of the V.O.N. provided a cleaning  
13 service; that is to say, they sterilized approximately  
14 35,000 needles and syringes for nurses. This is a job  
15 that is done by volunteers who have an interest in the  
16 public service of the community.

17 A service in a community is evoked by  
18 fund raising activities, it is a widespread participation  
19 on the part of members of the community.

20 People assuming responsibility cannot  
21 help but have a beneficial effect on the community.  
22 Furthermore, one must not lose sight of the economic  
23 value of the gratuitous services rendered by individuals  
24 to the V.O.N.

25 As to financing, the financial statements  
26 of the V.O.N. branches in Quebec for the year 1960 show  
27 that the total expenditures were approximately \$425,000  
28 and of this sum over 82% was expended on salaries. It  
29 should be appreciated, however, that this sum of \$425,000  
30 does not really represent the true cost of the services.







1 As I have previously mentioned, the  
2 services given gratuitously by public-spirited citizens,  
3 were they done on a commercial basis, would cost the  
4 agency a considerable amount of money.

5 In addition, the national Order provides  
6 us with a certain service here in Quebec at a nominal  
7 cost. Miss Roy is Regional Director for the Province  
8 of Quebec and is an employee of the national office.  
9 Her services and other services are provided by the  
10 national office at a nominal cost to Quebec.

11 It should be realized the true cost of  
12 the operation of the V.O.N. in Quebec, were it known,  
13 would undoubtedly be very much in excess of \$425,000  
14 that was spent in 1960.

15 This sum was raised roughly as follows:  
16 nursing fees, \$115,000. I should perhaps give a short  
17 explanatory comment. The policy of the V.O.N. is that  
18 a patient is given service regardless of his ability to  
19 pay.

20 We do have a charge which we attempt  
21 to collect and it varies probably in the various branches  
22 from \$2.50 to \$3.50, a minimum of \$2.50 to a maximum of  
23 \$3.50 a visit but wherever the patient is unable to pay  
24 then they are not obliged to pay.

25 A number of our visits are made  
26 completely free; another large number are made partially  
27 free and a proportion are fully paid.

28 Nursing fees account for \$115,000. We  
29 received approximately \$27,000 in municipal grants; we  
30 received \$271,000 from community appeals. Incidentally,







1 the Greater Montreal branch, the Sherbrooke branch and,  
2 I think, the Hull branch, are all part of community  
3 chests in their areas and other revenues accounted for  
4 \$12,000. It should be noted that to date the V.O.N.  
5 has received no financial support from the Government  
6 of the Province of Quebec.

7 In its own economic interest we believe  
8 that the Government, which has been deriving an economic  
9 benefit from the service provided by the V.O.N. and  
10 would derive further economic benefit from the expansion  
11 of the service, should encourage expansion of the service  
12 by financial aid. Thank you very much.

13  
14 --- The Hon. Chief Justice Emmett M. Hall takes the  
15 Chair from Commissioner McCutcheon.

16 THE CHAIRMAN: On that last point do  
17 you say you have had no revenue from the province: has  
18 any request been made for such help?

19 MR. KEEPING: Yes, they have been made  
20 and I have reason to believe they are receiving sympa-  
21 thetic consideration.

22 COMMISSIONER BALTZAN: I have no  
23 questions at the moment, Mr. Chairman.

24 COMMISSIONER GIRARD: Mr. Chairman,  
25 Mr. Keeping, I note that most V.O.N. branches have been  
26 establishing referral programs and liaison programs;  
27 would someone like to comment on the advantages of the  
28 referral program over the liaison program or vice versa?

29 MR. KEEPING: May I ask Miss Small to  
30





1 speak to that?

2 MISS SMALL: I don't really think,  
3 Miss Girard;- I think it is a matter of nomenclature.  
4 When we speak of the liaison program in the Montreal  
5 branch we think that the liaison program is where our  
6 Victorian Order of Nurses is full-time in the hospital.

7 Referral programs; they only spend  
8 part of a day, or only visit the hospital three times  
9 a week to pick up the referrals of patients transferred  
10 home. But in our three hospitals in Montreal we have  
11 a nurse on duty five days a week.

12 In the Montreal General and the Royal  
13 Victoria Hospital, and now at St. Mary's, she is there  
14 on a part-time basis three mornings a week. That is  
15 the difference we mean between the liaison and referrals.

16 COMMISSIONER GIRARD: Have you any  
17 tangible evidence of how much referral programs have  
18 contributed to the alleviating of the shortage of beds  
19 in the hospital? Could you give the Commission some  
20 idea of how many beds have been freed in any one of these  
21 hospitals because of the referral programs, and maybe  
22 some comparison? Is it increasing, or are you having  
23 more and more referral cases?

24 MISS SMALL: I think it is noticeable  
25 since hospitalization came into Quebec in 1961. Our  
26 referrals did increase noticeably in 1961. In 1961 we  
27 had 2,209 patients referred for continuing nursing care,  
28 as against 1960 we had 1,742. We are finding that also  
29 with the liaison nursing that we are getting patients  
30 that require much more intensive nursing care.





(1981)

PROVINCE OF QUEBEC  
DEPARTMENT OF HEALTH AND SOCIAL SERVICES

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1 In other words, they are needing daily  
2 visits and maybe visits at night. In other words, we  
3 do feel that when the home is suitable, and this is  
4 another advantage of our service, our nurses go and  
5 visit in that home to find out if the home is suitable  
6 before the patient is referred home, and in this way  
7 he can be referred home at a much earlier date.

8 And because we work so closely with  
9 the hospital personnel, it is a co-operative effort,  
10 and the hospitals are very conscious of getting the  
11 patients out of the hospital as soon as possible, if  
12 the home is suitable for the care of the patient.

13 MR. KEEPING: I think it is very  
14 difficult to actually give you tangible figures on  
15 this, because it would need really a controlled study,  
16 it would need the doctors for instance to make estimates  
17 of how much longer the patient would have been required  
18 to stay in hospital if visiting nurse services were not  
19 available.

20 That study was made in the State of  
21 New York in conjunction with the Blue Cross, and that  
22 certainly showed startling results, but it is very hard  
23 to give you figures without having a controlled study  
24 made.

25 We believe that it does result in a  
26 substantial degree of increase in early discharge from  
27 hospital, but we cannot give you figures.

28 COMMISSIONER GIRARD: But Mr. Keeping,  
29 I think we also realize that, and we have been given  
30 figures at places, and I think we all believe that this







1 is helping tremendously. Mi

2 Miss Small, since we have heard all  
3 through Canada about home care programs from V.O.N.'s  
4 and other agencies, and since everybody seems to feel  
5 that this is something that is very much needed at this  
6 stage in hospitalization plans, and since also I think  
7 that the V.O.N., Montreal branch, was one of the first,  
8 if not the first, I think the first in Canada to start  
9 a home care program in connection with the Reddy  
10 Memorial Hospital, would you care to tell us something  
11 about the home care program? Is it expanding, or what  
12 do you see in the way of its expansion and maybe speak  
13 also about the homemakers? Is this one of the big  
14 difficulties? How do you see the problems in this area?

15 MISS SMALL: Well, as you know, the  
16 home care plan at the Reddy Memorial is hospital-based.  
17 It was started in 1950 and set up with the Victorian  
18 Order, which had a contract with the Reddy Memorial  
19 Hospital to provide the visiting nurse service.

20 The Victorian Order nurse was not in  
21 the hospital as liaison. I think this program at the  
22 Reddy Memorial has certainly provided many benefits to  
23 the community. I don't think it has expanded, and I  
24 think maybe the reason is on account of relation to  
25 finance.

26 We find that at least the last five  
27 years it seems to be the patients that are being referred  
28 for home care, particularly in relation to nursing care,  
29 are patients primarily suffering with cancer, with

30 This is what we are finding, that it seems to





1 be predominantly a caseload of cancer patients, but as  
2 you know, when this program was initiated, it was provided  
3 with a special grant from the Province of Quebec.

4 I really don't feel I have the informa-  
5 tion in relation to the financing, because this was a  
6 hospital program, but I am given to understand that one  
7 of the reasons it has not expanded was definitely in  
8 relation to lack of money in order to finance its  
9 program, but the hospital has told me that they have  
10 allowed them an additional 40 hospital beds.

11 COMMISSIONER GIRARD: In connection  
12 with this, why do you think home care plans have not  
13 spread more rapidly than they have? We are talking  
14 about Montreal now, and the Province of Quebec, and we  
15 all seem to think that this is something that could be  
16 of tremendous value.

17 However, they haven't developed very  
18 readily. What are the obstacles to the development of  
19 home care?

20 MISS SMALL: I think one of the big  
21 obstacles of course comes back to our old problem,  
22 finances. There is just not enough money. The budgets  
23 are so limited in hospitals. It has not been sold to  
24 the public.

25 I think this is one of the things. I  
26 feel that hospital care had a great priority, and there  
27 has been lack of funds, and I think this is one of the  
28 reasons home care programs have not expanded.

29 I think hospital people, doctors,  
30 realize the benefits, but there just has not been







1 enough money, and I feel personally that money is not  
2 the primary reason for home care. It is that it provides  
3 a better type of care for a selected group of patients,  
4 and, of course, if a patient is coming home they have  
5 to have many more services than the visiting nurse  
6 service and it is the lack of somebody to go into the  
7 home and provide homemaking services in the home on a  
8 full-time basis.

9 We feel that even the Victorian Order  
10 could do much more work if there were a Homemaker  
11 Service in the City of Montreal.

12 COMMISSIONER GIRARD: Has the V.O.N.  
13 ever approached the Provincial Government for some money  
14 for home care programs?

15 MISS SMALL: V.O.N. in Quebec specifi-  
16 cally has not approached the Province of Quebec and I  
17 wouldn't like to say, but, of course, tomorrow you will  
18 be hearing that there is a home care plan now being  
19 sponsored. So we are hopeful that this will be extended  
20 to the other hospitals.

21 MR. KEEPING: The provincial organization  
22 has approached the Provincial Government on several  
23 occasions, and has stated its feeling that home care plans  
24 would be beneficial, but I don't think that the provincial  
25 Order, the provincial Order definitely has not asked for  
26 a grant in order to provide an integrated home care plan.

27 V.O.N. is a visiting nurse service.  
28 We look upon ourselves as just one part for a fully  
29 integrated home care plan, so we have told the Provincial  
30 Government that we think home care plans desirable, and







1 express our willingness to co-operate in them, but we  
2 have not asked for funds for the V.O.N. itself to imple-  
3 ment a home care plan.

4 COMMISSIONER GIRARD: Miss Small, we  
5 were saying that as well as money there are other  
6 facilities that are lacking for the implementation of  
7 home care plans, and one of them was homemakers, and  
8 such things.

9 What is being done for the development  
10 of such services as homemaker services? Some V.O.N.  
11 branches, I understand, have this service in the V.O.N.  
12 facilities.

13 I can think of one, and you probably  
14 know some of them.

15 MISS SMALL: I can only speak for  
16 Montreal, and I think our family service agencies,  
17 which are associated with our four federations, they  
18 are very much aware of the need of extending their home-  
19 maker services and there are two of these federations  
20 have definitely, this past year, provided extended  
21 services in relation to homemaker services.

22 There is a feeling that this is some-  
23 thing which must be given consideration in the community  
24 and there are two family service agencies which have  
25 increased their homemaker services this year but this  
26 is really at the present time just a drop in the bucket.

27 COMMISSIONER GIRARD: Under your present  
28 facilities you mention the educational programs, and in  
29 the educational programs you speak of the service that  
30 the V.O.N. is rendering to post-graduate basic degree



expressed their willingness to co-operate in them, but we have not asked for names for the V.O.N. itself to implement a home care plan.

There were several other people who were saying that as well as money there are other facilities that are lacking for the implementation of home care plans, and one of them was home-makers, and

What is being done for the development

of such services as home-maker services? Some V.O.N. branches, I understand, have this service in the V.O.N. facilities.

I can think of one, and you probably

know some of them.

MISS CHAIR: I can only speak for

Manchester, and I think our family service agencies,

which are associated with our town federations, they

are very much aware of the need of extending their home-

care services and there are two of these federations

have definitely, this past year, provided extended

services in relation to home-maker services.

I am in a feeling that this is some-

thing which must be given consideration in the community

and there are two family service agencies which have

extended their home-maker services this year but this

is really at the present time just a drop in the bucket.

There is a feeling that this is some-

thing which must be given consideration in the community

and there are two family service agencies which have

extended their home-maker services this year but this



1 students and undergraduates. I think this is a very  
2 important phase of the work of the V.O.N.

3 It is a tremendous contribution that  
4 the V.O.N. is doing in receiving undergraduate students  
5 and graduate and post-graduate students for observation,  
6 and what we call field work.

2 7 This is probably getting to a point  
8 where it is difficult for the hospital schools to get  
9 observation periods in visiting nursing agencies, and  
10 it is also difficult, I think, for the university  
11 schools to get as much of this experience as they wish.  
12 What is being done in this? Is this expanding, and  
13 how much of this can you do?

14 MISS SMALL: We are finding that more  
15 and more there are more demands being made on our organiza-  
16 tion here in Montreal for field work, because, of course,  
17 our universities, their student enrolment has enlarged,  
18 and we are finding that it is a matter of selecting  
19 very carefully now.

20 We are finding that we are having more  
21 demands made on us from the hospital schools of nursing  
22 and we are seriously considering that we will have to  
23 cut the period of observation for the hospital schools  
24 of nursing and devote more of our time to post-graduate  
25 study.

26 While this is a cost in time and prepara-  
27 tion, but also, of course, we are very glad to participate.  
28 It keeps us on our toes. It makes us become more aware  
29 all the time of what is going on in our fields of higher  
30 learning and also we are very dependent on it for







1 recruitment.

2 This is also a source of recruitment  
3 for us for personnel. But you are quite right, it is  
4 becoming more difficult to fill all the demands for  
5 field experience for these students.

6 COMMISSIONER GIRARD: Since this is a  
7 service that schools have been accustomed to getting  
8 from your organization, and since you will have to  
9 discontinue it, as you say, with great reluctance,  
10 have you any suggestions to offer in place of this?

11 MISS SMALL: I think our feeling in  
12 the V.O.N., we have talked about this a great deal and  
13 we have often wondered whether the nurses in the under-  
14 graduate programs could not obtain this type of service  
15 through their outdoors department.

16 It would cut down the length of time  
17 they would stay with us, and arrangements could be made  
18 whereby they could visit patients in the outdoors, and  
19 maybe go to visit with a V.O.N. nurse and we think this  
20 might be more profitable and cut down on the time.

21 COMMISSIONER GIRARD: That is a very  
22 good suggestion, Miss Small. To come back to another  
23 part of your brief; in the nursing fees, in the revenues,  
24 Table 6, you state 20.9% of your total receipts comes  
25 from fees. How does this compare with the amount in  
26 other branches, or in other provinces, do you know?

27 It seems low to me, but I may be way  
28 off, maybe this is normal, or as much as you can expect.  
29 Do you have any reasons for this percentage?

30 MISS SMALL: This is a provincial rate,

17

18 for us for personnel. But you are quite right, it is  
19 because some difficulty to fill all the needs for  
20 that experience for these students.

21 COMMISSIONER CHAND: Since this is a

22 service that schools have been accustomed to getting  
23 from your organization, and since you will have to  
24 discontinue it, as you say, with great reluctance,  
25 have you any suggestions to offer in place of that?

26 MISS SMITH: I think our feeling is

27 the V.O.N., we have talked about this a great deal and  
28 we have often wondered whether the nurses in the under-  
29 service programs could not obtain this type of service  
30 through their outdoor department.

31 It would cut down the length of time  
32 they would stay with us, and arrangements could be made  
33 whereby they could visit patients in the outdoors, and  
34 maybe go to visit with a V.O.N. nurse and we think this  
35 might be more profitable and cut down on the time.

36

37 good suggestion, Miss Smith. To come back to another  
38 part of your letter, in the nursing fees, in the revenue,  
39 Table 3, you state 20.00 of your total receipts comes  
40 from fees. How does this compare with the amount in  
41 other branches, or in other provinces, do you know?

42 It seems low to me, but I may be way

43 off, I am not so certain, but as near as you can expect.

44 Do you have any reason for this percentage?

45 MISS SMITH: This is a provincial rate,





1 and I am afraid I wouldn't feel at liberty to speak to  
2 this. For the Montreal branch we feel that our fees  
3 collection is on average for other branches. Maybe  
4 Miss Roy would have the information about the nine  
5 other branches, and it is possible it might be low.  
6 I really haven't looked at it that closely.

7 MISS ROY: Actually in some of our  
8 branches in the province the economic standards are  
9 higher than others, and probably the rates in a few of  
10 them are low in comparison to others, because of the  
11 type of patients that are making use of our services.

12 If it is in the area where they have  
13 a fairly high rate of hospital beds for the population  
14 we tend to get the people who are in the lower economic  
15 group and cannot pay the full fee.

16 However, in some of the other branches  
17 it evens out, that where hospital facilities may not be  
18 as adequate we get the patients from all categories and  
19 a higher economic basis, but I think perhaps that on the  
20 average the monies collected from fees are about the  
21 same.

22 COMMISSIONER GIRARD: What is your  
23 cost per visit?

24 MR. KEEPING: Those figures are available.  
25 I would be surprised if the Province of Quebec is substan-  
26 tially below the average across the country in our other  
27 provinces. We would be very glad to obtain the informa-  
28 tion and supply it to the Commission, but I certainly  
29 would be surprised if it is substantially lower in  
30 proportion of patient fees to total revenue.



and I am afraid I wouldn't feel at liberty to speak to this. For the Montreal branch we feel that our collection is an average for other branches. Miss Roy would have the information about the other branches, and it is possible it might be low. I really haven't looked at it that closely.

MISS ROY: Actually in some of our

branches in the province the economic conditions are higher than others, and probably the rates in a few of them are low in comparison to others, because of the type of patients that are making use of our services. It is in the area where they have a fairly high rate of hospital beds for the population we tend to get the people who are in the lower economic group and cannot pay the full fee.

However, in some of the other branches in some cases, that where hospital facilities may not be as adequate we get the patients from all categories and a high economic base, but I think perhaps that on the average the rates collected from fees are about the same.

Does that sound right?

MR. WATKINS: Those figures are available. I would be surprised at the Province of Quebec is above the average across the country in our other branches. We would be very glad to furnish the information and supply it to the commission, but I certainly would be surprised if it is substantially lower in some of our poorest areas to the northwest.



1 THE CHAIRMAN: We have had the figures  
2 from the other provinces. It is simply a matter of  
3 tabulating them, I think, ourselves.

4 COMMISSIONER GIRARD: In Table 2, under  
5 Other Visits, you have an item of 4,304 visits. I know  
6 that this means visits where the patient isn't seen, or  
7 on behalf of, and remembering my public health days, I  
8 remember that this used to be, we used to consider this  
9 as a costly item, so if your cost per visit is around  
10 \$3 and you have 4,000 visits at \$3, maybe you are smarter  
11 now than we used to be.

12 We used to wonder what to do about  
13 these visits. Are they a problem?

14 MISS SMALL: Yes, because many of our  
15 patients are in the lower income group, and, of course,  
16 they don't have telephones, and we sometimes have to  
17 make many visits to find patients at home. These are  
18 the chronic patients who need constant supervision and  
19 is not turning up at the clinic.

20 I think this is one of the reasons that  
21 this is a continuing problem; is to keep these visits  
22 down to a minimum and it certainly does up our costs if  
23 we have a lot of these types of visits.

24 COMMISSIONER GIRARD: I believe you  
25 have started using nursing assistance in your branch  
26 and I know it has been used in other branches. Would  
27 you like to tell us some of your experiences with the  
28 nursing assistants? How they fit into the general  
29 program, and what are the advantages and would you use  
30 more if you had more, or what is the ratio of nursing







1 assistants to public health nurses that you would like  
2 to keep?

3 MISS SMALL: In Montreal we only have  
4 two nursing assistants. The ratio that we agree would  
5 be one nursing assistant to twelve nurses. In Montreal  
6 we have the problem of travel and the two nursing  
7 assistants that we have, we feel they are rendering a  
8 very valuable service to the community.

9 Their caseload is selected. It is  
10 different to the other nurse. It must be selected on  
11 account of the type of nursing the nursing assistant is  
12 able to perform and she works under the direction of  
13 the registered nurse.

14 We feel that these two nurses have  
15 allowed the better utilization of our public health  
16 nurse. In other words, they are able to provide, and  
17 I do not like using the word custodial care because I  
18 think it is a word none of us really know what custodial  
19 means, but these nurses are able to take over many older  
20 people who need continual care, maybe for the rest of  
21 their life.

22 The nursing assistant does provide an  
23 excellent service and the public health nurse does  
24 visit in this home every fifth visit. We could expand  
25 our staff of nursing assistants. We cannot keep her  
26 under constant supervision in the community so therefore  
27 they have to be very carefully selected.

28 COMMISSIONER GIRARD: Would you like  
29 to use the services of male nurses, if they were available?

CC/AG/dpw 30 MISS SMALL: I think this is one area







1 that we can certainly use male nurses. There are many  
2 patients, heavy patients, male patients and particularly  
3 paraplegics that we really could utilize male nurses.

4 Unfortunately, as you know, in Quebec,  
5 male nurses are not allowed to practise.

6 COMMISSIONER GIRARD: Thank you very  
7 much, Miss Small. I think you have given this Commission  
8 very valuable information.

9 THE CHAIRMAN: Dr. Firestone?

10 COMMISSIONER FIRESTONE: If I may  
11 pursue the question of finance for a few moments with  
12 you and your associates; I think you make mention on  
13 page 19 of your brief a strong case why the Government  
14 should participate in the financing of your services  
15 and you say, as a result of V.O.N. services, the Govern-  
16 ment cost of hospitalization has been reduced, 1. by  
17 enabling earlier discharge, 2. by reducing the incidence  
18 of re-admission and 3. by rendering unnecessary initial  
19 admission.

20 This is a valuable service and it is a  
21 service that contributes to achieving economics and  
22 using our limited hospital facilities.

23 Now, sir, you have suggested that you  
24 have approached the Provincial Government for some  
25 financial assistance. The problem seems to us, it is  
26 perhaps somewhat broader because the Federal Government  
27 contributes approximately 50% of the cost of hospitaliza-  
28 tion and therefore we would appreciate if you could offer  
29 us some advice of what sort of financial assistance you  
30 expect from the Government.





1 I am using the term "government" now in  
2 the broader sense; the provincial and the Federal Govern-  
3 ment, since the Federal Government contributes approxi-  
4 mately 50% of the cost of hospitalization.

5 Have you a figure in mind such as, say,  
6 one dollar or two dollars per visit?

7 MR. KEEPING: Well, Dr. Firestone, if  
8 it were going to be based on a per-visit basis I think  
9 it would be fair to say one would expect assistance on  
10 the basis of the cost per visit.

11 Personally, as I have already said, I  
12 feel the retention of the V.O.N. as a voluntary agency  
13 is a very important thing in the community. I therefore  
14 don't feel - we don't feel that the V.O.N. should be  
15 wholly supported by the Government.

16 We believe that the community should  
17 play its part in the support of the service. I feel  
18 that at this stage the Government might fairly be asked  
19 to make a grant rather than a per-visit basis and perhaps  
20 that grant be hinged on expansion of services, expansion  
21 territorially and expansion of the scope of the service  
22 and perhaps to look at that later and assess what success  
23 the program had met with.

24 COMMISSIONER FIRESTONE: What kind of  
25 grant would you have in mind, Mr. Keeping?

26 MR. KEEPING: I have no specific figure  
27 in mind at all. It would depend only upon the strings  
28 that might be attached to the grant, to the expansion  
29 of the service, either of the scope of the service or  
30 the territorial expansion that would be expected as a







1 result of the grant.

2 COMMISSIONER FIRESTONE: You understand,  
3 Mr. Keeping, we are much in sympathy with the objectives  
4 of the V.O.N. and the wonderful work you have done under  
5 the auspices of the Association.

6 However, if there are recommendations  
7 to be made to the Government as to offering some grant  
8 we would have to have some idea of what would be helpful  
9 and what would be the result if such a grant was given.

10 Perhaps I could go at the same point  
11 in a different way, Mr. Keeping. What are your require-  
12 ments to expand the service the V.O.N. now gives to  
13 provide more adequate services to the people in the  
14 Province of Quebec?

15 MR. KEEPING: That I can't answer in  
16 terms of dollars. As I mentioned earlier we believe  
17 that one field in the scope of our service that could benefi-  
18 cially be expanded would be in home care plans.

19 That would be dependent upon the  
20 availability of other services, such as homemaker  
21 services, in order to be able to do that. I regret I  
22 don't think I can be expected to put a figure on that.

23 COMMISSIONER FIRESTONE: Now, sir, if  
24 you had an opportunity to open several more branches  
25 where would those branches be opened in the Province of  
26 Quebec?

27 THE CHAIRMAN: Table 7.

28 COMMISSIONER FIRESTONE: In terms of  
29 priority?

30 MR. KEEPING: The V.O.N. is not the







1 only visiting nurse service within the province. There  
2 is La Société des Infirmières Visiteuses and there are  
3 several religious orders already operating.

4 On Table 7 of our brief we do mention  
5 a number of areas where we don't believe there are  
6 visiting nurses available. We don't have definite  
7 information. They are listed as: Granby, Magog,  
8 Drummondville, Knowlton, Lower St. Lawrence, Seven  
9 Islands, Lake St. John, Chateauguay and St. Bruno.

10 These are just some areas. It should  
11 by no means be taken as an exhaustive list.

12 COMMISSIONER FIRESTONE: Would the  
13 V.O.N. have a priority that you would think certain  
14 areas require such services more urgently than others?  
15 One can't establish services in all these areas at the  
16 same time. Have you any priority, say, within the next  
17 two years, for example, that you would aim to establish  
18 such a new service?

19 MR. KEEPING: We haven't ever looked at  
20 it this way, Dr. Firestone. Dependent as we are, as I  
21 think we should be upon community support and community  
22 financing, to a large extent the initiative for the  
23 opening of new branches is coming from the communities  
24 and as I mentioned earlier, just recently an approach  
25 was made to us from Fort Cartier.

26 We have really made no estimation.

27 COMMISSIONER FIRESTONE: Now, sir, if  
28 you were to open a new branch, how much money is required  
29 to get started? I am just getting some guidance from  
30 you.





1 THE CHAIRMAN: It might be how big a  
2 branch is going to be established. Wouldn't that be  
3 the answer?

4 MR. KEEPING: I think it is fair, is  
5 it not, Miss Roy,- I think a one-nurse branch requires  
6 approximately \$10,000 a year to operate and that  
7 includes probably - it does include the salary of the  
8 nurse, a car, at least the capital cost on an annual  
9 basis of a car and the requisite office facilities.  
10 That is our experience, is it, not?

11 MISS ROY: Yes, for initial opening of  
12 a one-nurse branch, \$10,000 a year, and then we feel  
13 the operating cost following the first year is \$6,000  
14 to \$7,000 per year.

15 COMMISSIONER FIRESTONE: Mr. Keeping,  
16 trying again to get at some understanding of what  
17 financial support is required, assuming that an annual  
18 grant of \$50,000 was made to V.O.N. by the Province of  
19 Quebec, would that amount, on an annual basis, enable  
20 you to provide extended services with the result that  
21 there may be a further economy achieved in the utiliza-  
22 tion of hospital beds in the province?

23 MR. KEEPING: I think definitely it  
24 would. I think that if it were given to us on the  
25 understanding that we would endeavour to open new  
26 branches we would actively look into those areas where  
27 it was needed. I think we would attempt to stimulate  
28 community interest in it and enter into an active  
29 program in inaugurating new branches in the area.

30 COMMISSIONER FIRESTONE: Would you feel,





The Chairman: It might be how long a

branch is going to be established. Wouldn't that be

the answer?

MR. KEMPING: I think it is fair, is

it not, Miss Roy? - I think a one-nurse branch requires

approximately \$10,000 a year to operate and that

includes probably - it does include the salary of the

nurse, a car, at least the capital cost on an annual

basis of a car and the requisite office facilities.

That is our experience, is it, not?

MISS ROY: Yes, for initial opening of

a one-nurse branch, \$10,000 a year, and then we feel

the operating cost following the first year is \$6,000

or thereabouts.

Now, if we have a branch in a new area, we

try to get at some understanding of what

financial support is required, assuming that an annual

grant of \$20,000 was made to V.C.N. by the Province of

Quebec, would that amount, on an annual basis, enable

you to provide extended services with the result that

there may be a further economy achieved in the utilization

of hospital beds in the province?

MR. KEMPING: I think definitely it

would. I think that if it were given to us on the

understanding that we would endeavor to open new

branches we would actively look into those areas where

it was needed. I think we would attempt to stimulate

community interest in it and enter into an active

program in investigating new branches in the area.

COMMONS LEADER: Would you feel,



1 sir, that the result of such a grant would be to save  
2 the two governments, that is, the Government of the  
3 Province of Quebec and the Federal Government that  
4 contributes to hospital insurance programs, amounts in  
5 excess of the \$50,000 grant because of the ability of  
6 people to stay perhaps fewer days in the hospital, or  
7 perhaps avoiding some people going back to the hospital  
8 that didn't require hospital treatment. Would that be  
9 your view?

10 MR. KEEPING: I would say it would  
11 definitely save a substantial amount of money. Whether  
12 in its first years it would save exactly or more than  
13 \$50,000, I wouldn't care to say. I have no means of  
14 estimating. I think over a period of time when the  
15 service developed, it would more than pay for itself.

16 COMMISSIONER FIRESTONE: Thank you  
17 very much.

18 THE CHAIRMAN: Dr. Baltzan?

19 COMMISSIONER BALTZAN: I just have two  
20 things, sir. You repeatedly refer to your wish to  
21 preserve the voluntary aspect of this body. You must  
22 have some very good reasons. I think we all know some  
23 of them. Could you just quickly state the position of  
24 the voluntary aspect of such an organization as against  
25 some other form, say, a fully-paid service?

26 MR. KEEPING: I think the principal  
27 reason is that it means that the community is interested  
28 in the service, otherwise they don't have it. I think  
29 therefore it promotes the responsibility of the citizen,  
30 which I think is a most important thing.







1 I think, too, it is possible, under a  
2 voluntary organization, the service might conceivably  
3 be perhaps a little more enthusiastic than it might be  
4 under some other form. There is also the economic  
5 benefit because you get services of a lot of citizens  
6 for nothing.

7 The principal point in my mind is that  
8 it involves the responsibility of the citizens of the  
9 community, which I think is a very, very important  
10 factor.

11 COMMISSIONER BALTZAN: Thank you.  
12 That is very good. One more thing: should you have a  
13 considerable amount of government support what do you  
14 think the effect might be then on your appeals for  
15 public contributions?

16 MR. KEEPING: I feel, and I think we  
17 say in this petition, that we would like to have support  
18 from the Provincial Government for expansion of the  
19 services, but without detracting from our present  
20 sources of revenue.

21 We feel that it is important to retain  
22 the voluntary interest in the V.O.N. and therefore we  
23 don't ask for money from the Government as a substitute  
24 for the funds we are now obtaining.

25 COMMISSIONER BALTZAN: You imply you  
26 don't want any strings attached?

27 MR. KEEPING: No, I think it would be -  
28 I say we want it for expansion, and therefore I think  
29 it would be quite fair to put strings on.

30 COMMISSIONER BALTZAN: Sort of earmarking?



I think, too, it is possible, and a

voluntary organization, the service might conceivably be given a little more enthusiastic than it might be under some other form. There is also the economic benefit because you get a lot of citizens for nothing.

The principal point in my mind is that it involves the responsibility of the citizens of the community, which I think is a very, very important

COMMITTEE REPORT: Thank you,

That is very good. One more thing: should you have a considerable amount of government support what do you think the effect might be then on your appeals for public contributions?

MR. KAPLAN: I feel, and I think we say in this petition, that we would like to have support from the Federal Government for expansion of the services, but without depending from our present sources of revenue.

I feel that it is important to maintain the voluntary interest in the V.O.M. and therefore we don't want any money from the Government as a substitute for the money we are now obtaining.

don't want any strings attached?

MR. KAPLAN: No, I think it would be

I say we want it for expansion, and therefore I think

I would be quite sure to put it down on

COMMITTEE REPORT: Some of the following



1 MR. KEEPING: That is right.

2 THE CHAIRMAN: Mr. McCutcheon?

3 COMMISSIONER McCUTCHEON: Mr. Keeping,  
4 am I right in making this supposition: that, assuming  
5 you received this hypothetical grant of \$50,000 against  
6 the undertaking that you would expand, endeavour to  
7 expand your services - to expand your services, that  
8 you would still under the policy of the Victorian Order  
9 of Nurses, not go into a community in which you weren't  
10 assured of community support?

11 MR. KEEPING: I think that is right.

12 COMMISSIONER McCUTCHEON: In the way  
13 of both funds and a local board and so on; in other words,  
14 you wouldn't simply move in cold?

15 MR. KEEPING: That is quite correct.

16 COMMISSIONER McCUTCHEON: Thank you.

17 THE CHAIRMAN: Thank you very much, Mr.  
18 Keeping and those who are associated here with you this  
19 afternoon. As you know we have had submissions from  
20 the Victorian Order of Nurses in the several provinces  
21 where we have appeared and we are, for that reason and  
22 for others, well acquainted with the work and perhaps  
23 don't find it necessary to go as deeply into the indivi-  
24 dual briefs here this afternoon as we might otherwise  
25 have to do if we didn't have the advantage of having  
26 heard submissions in the other provinces.

27 We will be hearing the national submission  
28 in Toronto. Thank you very much for your assistance here  
29 this afternoon.

30 MR. KEEPING: Thank you.



COMMISSIONER McOUTCHAM: Mr. Keegan,

or I think in making this suggestion that, assuming  
you received an hypothetical amount of \$50,000 against  
the understanding that you would remain, and assuming that  
you would still under the policy of the Victorian Order  
of Nurses, not go into a community in which you were not  
and not of community support?

MR. KEEGAN: I think that is right.

COMMISSIONER McOUTCHAM: In the way

of both kinds, substantial board and so on, in other words,  
you would not stay in the city?

MR. KEEGAN: That is quite correct.

COMMISSIONER McOUTCHAM: Thank you.

MR. McOUTCHAM: Thank you very much, Mr.

Keegan, and those who are associated with you this  
afternoon. As you know we have had a discussion in  
the Victorian Order of Nurses in the several provinces  
where we have appeared and we are, for that reason, and  
for others, well acquainted with the work and people  
don't find it necessary to go as deeply into the details  
that might have this afternoon as in a brief statement  
have to do it we could do it in the evening, or in having  
some information in the other provinces.

We will be meeting the national association

in London. Thank you very much for your kind words and

this afternoon.



1 THE CHAIRMAN: We will take a short  
2 recess and then continue with the Association of Nurses  
3 of the Province of Quebec.

4  
5 --- Short Recess

6  
cH/dpw 7 THE CHAIRMAN: We will come to order  
8 and proceed with the Association of Nurses of the  
9 Province of Quebec and it will be Exhibit 219 for the  
10 French edition and 219A for the English edition.

11  
12 --- EXHIBIT NO. 219: Submission of the Association  
13 of Nurses of the Province of  
Quebec. (French edition)

14 --- EXHIBIT NO. 219A: Submission of the Association  
15 of Nurses of the Province of  
Quebec. (English edition)

16  
17 SUBMISSION OF THE ASSOCIATION OF NURSES  
18 OF THE PROVINCE OF QUEBEC

19 Appearances: Miss Eve M. Merleau  
20 Miss Helene Lamont  
21 Sister M. Decary  
22 Miss Alice Gage  
23 Miss Genevieve Lamarre  
Sister Thomas du Sauveur  
Miss H.F. Reimer  
Miss Gagnon

24 MISS REIMER: Mr. Chairman, ladies and  
25 gentlemen, I have the honour to introduce the Chairman  
26 of the Association of Nurses of the Province of Quebec,  
27 who will present the brief.

28 MISS MERLEAU: Mr. Chairman, ladies  
29 and gentlemen, this brief presented to the Royal  
30 Commission on Health Services was prepared by the







1 Association of Nurses of the Province of Quebec and  
2 approved by the members of the Association. I will  
3 give the summary of the main points of the brief.

4 I. The changing demands upon  
5 nursing. (Paragraphs 21, 22, 23, 24, 25)

6 II. Inadequate preparation of nurses:

7 (1) Lack of facilities in general educa-  
8 tion for pre-nursing students. (Para-  
9 graphs 48, 49, 50, 51, 52, 53)

10 (2) Inadequacy of the present basic  
11 nursing education programmes to prepare  
12 nurses for existing and future needs.

13 (Paragraphs 24, 29, 30, 31, 34, 70, 71)

14 III. Lack of qualified nurse practi-  
15 tioners, head nurses, nurse educators and nurse admini-  
16 strators. (Paragraphs 18, 19, 20, 21, 22, 23, 24, 29,  
17 30, 31, 39, 60, 61)

18 IV. The importance of adequate finan-  
19 cial assistance for nursing education programmes, basic  
20 and post-basic, and for post-graduate study. (Paragraphs  
21 63, 64, 66, 69)

22 V. The necessity for economic condi-  
23 tions in the nursing profession to be on par with those  
24 in comparable professions in order to attract and retain  
25 nursing personnel. (Paragraphs 19, 20, 63, 88)

26 VI. The conviction of this Association  
27 that basic nursing education must be a joint effort of  
28 the general education authorities, the universities, the  
29 hospitals and public health agencies in order to prepare  
30 a nurse who will have the knowledge as well as the





1 intellectual skills necessary for the practice of her  
2 profession. (Paragraphs 75, 76, 77, 78, 79, 80, 81)

3 Conclusion

4 In this decade of unprecedented techno-  
5 logical progress, the profession has been so occupied  
6 with the urgent and heavy demands of the present that  
7 it has not been able to make those adaptations and  
8 changes in nursing and nursing education which would  
9 have enabled it to keep pace with the changes in health  
10 and medical care.

11 As a result, nurses are performing  
12 tasks and occupying positions for which, through no  
13 fault of their own, they are not at all prepared.

14 There is confusion about the components  
15 of nursing and about the role of the nurse.

16 An increase in numbers of nursing  
17 personnel will not solve the problem; the need is for  
18 more nurses better qualified to care for the patient  
19 and for nurses qualified to lead; without competent  
20 leaders, nursing cannot fulfil its obligations to society  
21 and to the profession.

22 A rethinking of the whole concept of  
23 nursing seems to be indicated. Studies and research  
24 basic to such a rethinking are presently being directed  
25 by the Canadian Nurses' Association.

26 While the situation is being studied,  
27 no time should be wasted in making those changes and  
28 improvements in nursing education which are essential at  
29 this time and which have been indicated in this brief.

30 If nursing is to attract and to retain







1 women of calibre, it will have to offer salaries and  
2 opportunities for professional advancement on par with  
3 those of comparable professions.

4 THE CHAIRMAN: Thank you, Miss Merleau.

5 COMMISSIONER GIRARD: Mr. Chairman,  
6 Miss Merleau, I shall direct questions to you as President  
7 but, of course, you are free, in any case, to ask any  
8 of your colleagues to answer the point made as you wish.

9 Now, in order to establish for the  
10 information of the Commission, I see that you have  
11 entitled the first page "Summary of the Main Points of  
12 the Brief" and I take it there are no recommendations  
13 herein?

14 MISS MERLEAU: No, we have no recommen-  
15 dations, we have simply a conclusion.

16 COMMISSIONER GIRARD: The conclusion  
17 is that which is on page 5 of Part 2; is that correct?

18 MISS MERLEAU: Page 20 and 21.

19 COMMISSIONER GIRARD: Your page 5;  
20 the second part is simply an opinion, not a conclusion?

21 MISS MERLEAU: Yes.

22 COMMISSIONER GIRARD: To take now the  
23 summary of the main points of the brief on the initial  
24 page un-numbered; first you have the changing demands  
25 upon nursing and you mention five paragraphs.

26 Now, among these five paragraphs there  
27 is paragraph 23 which says:

28 "In this changing picture of medical  
29 care, the position as delegated to  
30 the nurse, some of the tasks that



women of color, it will have to offer salaries and opportunities for professional advancement on par with those of comparable professionals.

THE CHAIRMAN: Thank you, Miss Merriam.

Miss Merriam, I shall direct questions to you as President, but, of course, you are free, in any case, to ask any of your colleagues to answer the point made as you wish. Now, in order to establish for the

information of the Commission, I see that you have entitled the first page "Summary of the Main Points of the Brief" and I take it there are no recommendations

MISS MERRIAM: No, we have no recommendations.

Therefore, we have simply a conclusion.

COMMISSIONER GILBERT: The conclusion

is that which is on page 5 of Part 2, is that correct?

MISS MERRIAM: Page 20 and 21.

COMMISSIONER GILBERT: Your page 5,

the second part is simply an opinion, not a conclusion, is it?

MISS MERRIAM: Yes.

COMMISSIONER GILBERT: To be sure the

summary of the main points of the brief on the initial

page on covered; that you have the opening demands

been meeting and you mention the paragraphs.

Now, among these five paragraphs there

is paragraph 2, which says:

"In this changing picture of modern

life, the position as delegated to

the nurse, some of the tasks that





1 she previously performed and for  
2 which her education has not prepared  
3 her."  
4 Now, the point of delegation of certain  
5 tasks which, up to the present, have been recognized  
6 as tasks within the medical field to a point which is  
7 very much debated; in your view should nurses, after  
8 agreement with the medical profession, decide jointly  
9 with the medical profession, first, what I mean, to  
10 decide what are the functions which, up to now, have  
11 been recognized as medical would, by common agreement,  
12 become functions which would fall within the nursing  
13 profession.

14 Would you be in favour of that or what  
15 is your view on that point? Should nurses, after agree-  
16 ment with the medical profession, decide which functions  
17 would become proper functions for the nursing profession?

18 MISS MERLEAU: I think to answer your  
19 question I will mention another point in the brief where  
20 we have mentioned that the nurse today exists but in  
21 the future we shall have to have a second person so if  
22 the functions of the second person are fairly similar  
23 to those which the nurse now assumes, necessarily the  
24 level of the nurse, as we understand the term today,  
25 must be a little higher.

26 In that case we believe there should  
27 be agreement of the entire problem on these matters  
28 with which we deal now in the medical field and should  
29 be restudied and there may be an expansion of agreement  
30 according to the various medical acts.



which the education has not prepared

Now, the point of delegation of certain

tasks which, up to the present, have been recognized

as tasks within the medical field as a point which is

very much debated; in your view should nurses after

agreement with the medical profession, decide, jointly,

with the medical profession, first, what I mean, to

decide what are the functions which, up to now, have

been recognized as medical work, by common agreement,

become functions which would fall within the nursing

profession.

Would you be in favour of that or not?

Is your view on that point? Should nurses, after agree-

ment with the medical profession, decide which functions

would become proper functions for the nursing profession?

MRS. WELLS: I think to answer your

question I will mention another point in the brief where

we have mentioned that the nurse delay exists but in

the future we shall have to have a second person so if

the question of the second person are fairly similar

to those which the nurse now assumes, necessarily the

level of the nurse, as we understand the term today,

must be a little higher.

In that case we believe there should

be agreement of the entire profession on these matters

with which we deal now in the medical field and should

be mentioned and there may be an experimental agreement

according to the various medical acts.



1       COMMISSIONER GIRARD: You believe that  
2       sincermedicine is progressing in any case between us  
3       necessarily, it does confirm the point of nurses'  
4       functions being different and so forth and it is  
5       important that such functions be taken on by them in  
6       their profession?

7       MISS MERLEAU: Yes, we find responsibility  
8       and it is always delegated by the doctor but from a  
9       legal point of view we have nothing legally, we have no  
10      guarantee or protection.

11      COMMISSIONER GIRARD: Miss Merleau, in  
12      answering that question you raised a subject which is  
13      in another field and we might deal with that now.

14      This is the matter of the second person;  
15      as that person is sometimes called, the unknown nurse  
16      because she has no name just now, a person everyone is  
17      speaking of in the nursing world.

18      What are your views regarding this  
19      other person, where would she be situated in the profes-  
20      sion if she is within the profession? Where would she  
21      be situated if she was outside the profession? What  
22      would her functions be and what would her relations be  
23      to the profession?

24      MISS MERLEAU: If I may I will ask Miss  
25      Lamont to answer that point.

26      MISS LAMONT: I do not think we can,  
27      at this time, answer that question. If I understand  
28      correctly, you mentioned this second nurse as being  
29      outside the profession but that might not be necessary;  
30      she could be a member of the profession. We do not think





COMMISSIONER STARR: Now believe they

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sion if she is within the profession? Where would she

be situated if she was outside the profession? That

would her functions be and what would her relationship be

to the profession?

MISS MERRILL: If I may, I will call Miss

Harriet to answer that point.

MISS LAMONT: I do not think we can

at this time, answer that question. If I understood

correctly, you mentioned this second nurse as being

outside the profession but that might not be necessary,

she could be a member of the profession. I do not think



1 we can define at this time the functions of this second  
2 nurse.

3 We have said in our brief that the  
4 role of what we mean by nursing care and the role of  
5 the nurse will have to be examined and rethought.

6 This question of the delegation of  
7 functions, of the tasks of the medical profession to  
8 the nurses, will have to be considered.

9 In view of all this I do not think we  
10 are ready at this point to say what the functions or  
11 the role of this second nurse will be. We know we need  
12 this person, that she should be well-trained and should  
13 be licensed. I do not know if that answers your  
14 question.

15 COMMISSIONER GIRARD: I do not neces-  
16 sarily mean she should be outside; I said wherever you  
17 would choose to have her; I was asking for some informa-  
18 tion on this.

19 Now, we are all agreed, in the profession  
20 or everybody seems to be agreed that there should be a  
21 second person. Everyone is talking about this other  
22 person, this other nurse but we are all saying we do  
23 not know what she should be, where she should be. Where  
24 are we going to get this information and who is going to  
25 say for us what this second person should be?

26 MISS LAMONT: We believe that we are  
27 living in a day of great change and while we say at  
28 this time that we cannot say, we cannot make a statement  
29 regarding her role, we study this question and we are  
30 rethinking it and we do believe that where the







1 Association has a responsibility in finding an answer  
2 together with all the other people in the field of health,  
3 it is impossible to answer this question alone without  
4 looking into the education of the nurse.

5 When once we begin improving the educa-  
6 tional situation and improving the education and the  
7 schools as we have discussed in this brief, some of the  
8 answers to this question will evolve, we believe.

9 COMMISSIONER GIRARD: Some associations,  
10 some provincial nursing association briefs have advocated  
11 that this so-called nurse, whatever she is, she is  
12 unknown, an un-named person, but she should be outside  
13 the hospital school or outside any of the schools that  
14 exist now in a different setting. What is your opinion  
15 about this?

16 MISS MERLEAU: I should like to ask  
17 Sister Décary to answer that question.

18 SISTER DÉCARY: The experience in other  
19 provinces or in other countries such as in the United  
20 States of America, we see from that experience that  
21 girls are trained in special schools outside of hospitals.  
22 Perhaps this would be a solution to be advocated here.

23 However, in our present hospitals, if  
24 we are going to adopt such a solution, certain modifica-  
25 tions would enable us to train such people. It is  
26 rather a question that I am raising rather than an  
27 answer I am providing.

28 THE CHAIRMAN: Just going back one  
29 phase on this question of the nurse doing work in this  
30 marginal field that you mentioned, is it the view of the





1 Nursing Association of Quebec that you would want your  
2 nurse further trained to assume these duties which are  
3 devolving upon her and in this way perhaps save medical  
4 manpower?

5 MISS LAMONT: Well, sir, if I speak,  
6 I do not believe I can speak for all the members of the  
7 Association but it seems in this changing picture of  
8 medical and health care, that the nurse is assuming  
9 more and more, or the doctor is delegating to the nurse,  
10 more and more duties that he previously performed, as  
11 we have said. The nurse is now performing them without  
12 legal protection and it seems that is the direction in  
13 which we are going.

2 14 We know that some nursing associations  
15 believe that the nurse should stay in her own field and  
16 say "Leave this to the medical profession". In other  
17 parts of the world there also is the thinking that we  
18 should perhaps go along with this and that this is a  
19 question that should be very closely studied and  
20 discussed with the medical profession and perhaps there  
21 is no reason why we should not go along with it.

AG/dpw 22 COMMISSIONER GIRARD: Somewhere in this  
23 brief, I don't know which page it is, you mention an  
24 experiment that could be undertaken between the nursing  
25 schools and the hospital schools. Now, is it the idea  
26 of the Association, or the authors of this brief? Could  
27 you elaborate this experiment for us and tell us the  
28 details of it?

29 MISS MERLEAU: I don't exactly understand  
30 your question.







1 COMMISSIONER GIRARD: On page 19 it  
2 states, paragraph 79, the association of one or two  
3 universities in collaboration with several schools at  
4 hospitals which will be part of a new plan for training  
5 nurses. Is it your idea here to have only a university  
6 system of nurse training, or do you have in mind a  
7 joint one?

8 MISS MERLEAU: Well, I think that it  
9 must be a joint effort up to a certain point, because  
10 education can be undertaken in the university, but there  
11 is also clinical work to be done. Naturally the hospital  
12 must join in this effort, whatever be the length of the  
13 curriculum, and whether or not a diploma or certificate  
14 or degree is awarded.

15 However, the program can be of varying  
16 lengths but it could be carried on in a university or  
17 in a hospital.

18 COMMISSIONER GIRARD: But when you say  
19 we hope that this plan will be the beginning of a new  
20 system for the education of professional nurses, is this  
21 a new system, because there are university programs in  
22 existence at the present time.

23 These programs are organized in collabo-  
24 ration with the schools.

25 MISS MERLEAU: Well, we have a program -  
26 there is a university program in McGill. At the  
27 beginning of 1962 another program has been begun, which  
28 was affiliated with the universities and thereafter we  
29 hope that with the help of our nursing faculties in the  
30 University of Montreal we will have another curriculum.







1 It will perhaps be a different curriculum  
2 from that of the schools already established. Did I  
3 answer your question?

4 COMMISSIONER GIRARD: Well, I thought  
5 there was more underlying this question. I thought  
6 perhaps there was a plan envisaged, a joint plan, in  
7 which you already had set out the main outlines of your  
8 scheme.

9 Now, in connection with the universities,  
10 since we are speaking of this topic, the brief of the  
11 Association of Canadian Nurses mentioned quite recently  
12 that it was hoped to train around 25% of nurses at the  
13 university level. This was a goal to be attained.

14 The target was to have been about 25%  
15 of nurses trained at the universities. What does your  
16 Association think of this goal?

17 MISS REIMER: Well, madam, we hope that -  
18 well, I should not say very soon but within the near  
19 future, within the next five years or so, that we might be  
20 able to prepare a certain percentage of our nurses in  
21 the university.

22 I don't know if we can say 25%, but  
23 certainly we hope that it will not be too long before;  
24 well, a certain percentage of our nurses could be  
25 prepared in the university, but when we are talking here  
26 about this program, this joint program of the university  
27 and the hospitals, we thereby wanted to say that we don't  
28 believe that a nurse can be educated in the university  
29 alone. It requires the collaboration of the hospital  
30 and public health field.



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The target was to have been about 25%  
of nurses trained at the universities. What does your  
Association think of this goal?

MRS. RUMBLE: Well, indeed, we hope that  
well, I should not say very soon but within the near  
future, within the next five years or so, that we might be  
able to increase a certain percentage of our nurses in  
the university.

I don't know if we can say 25%, but  
certainly we hope that it will not be too long before;  
well, a certain percentage of our nurses could be  
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and the hospitals, we thereby wanted to say that we don't  
believe that a nurse can be educated in the university  
alone. It requires the collaboration of the hospital.



1 She has to have her clinical practice  
2 and we hope eventually, in 50 years from now, that all  
3 our professional nurses will be prepared in the univer-  
4 sities. I am going perhaps a little too far, but I  
5 hope so.

6 THE CHAIRMAN: How many years did you  
7 say?

8 MISS REIMER: I said 50 years, sir.

9 COMMISSIONER GIRARD: Of course, Miss  
10 Reimer, the 25% was a goal. It was not a figure that  
11 anyone had many any research on, it was a goal for the  
12 coming years and it was stated - I don't think it was  
13 in the brief but this came up during the discussions and  
14 it was stated that this was a goal that we should try to  
15 attain; that about 25% of our nurses should be graduates  
16 from university schools.

17 Now, do you, or does any of your  
18 associates, like to speak of the future of hospital  
19 schools? I believe there is a great deal of confusion  
20 amongst the population, the general public, concerning  
21 hospital schools.

22 Certain individuals interpreted some  
23 of the statements made by nurses to mean that there  
24 will be a forthcoming abolition of hospital schools,  
25 that they will be eliminated soon.

26 Naturally, many other individuals are  
27 somewhat more optimistic, but when the profession itself  
28 makes statements in the newspapers or before such  
29 Commissions as the present one, these statements are  
30 circulated and this, of course, spreads a great deal of





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THE CHAIRMAN: How many years did you  
MISS BELMONT: I said 50 years, sir.  
COMMISSIONER GIBBARD: Of course, Miss  
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will be a thoroughly abolition of hospital schools,  
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Naturally, many other individuals are  
somewhat more optimistic, but when the profession itself  
makes statements in the newspapers or before such  
a gathering as the present one, these statements are  
often misunderstood and, of course, spreads a great deal of



1 uncertainty amongst the public.

2 Now, we want to know what the attitude of  
3 your Association is with respect to the hospital schools.  
4 What would you like these schools to become? What is  
5 your program in order to improve the hospital schools,  
6 if you wish to retain them?

7 MISS MERLEAU: Well, I should like to  
8 ask Miss Gagnon to answer this question. She visits  
9 these schools.

10 MISS GAGNON: I believe that I am not  
11 the most appropriate person to answer this question.  
12 I believe the Chairman of the School Committee would be  
13 more in a position to give an authorized opinion on  
14 this point.

15 MISS LAMONT: I think we have discussed  
16 this point at great length and our feeling is that we  
17 have to be practical for the moment and that hospital  
18 schools, which have been organized and which will carry  
19 on our needs for some time, must be upgraded and improved  
20 and will probably continue.

21 We also have the feeling that the  
22 professional nurse must be upgraded into the university  
23 level. That this second-level nurse, whatever or whoever  
24 she may be, could be an upgraded nursing assistant and  
25 this person might find themselves either in a separate  
26 institution outside the hospital or be trained in the  
27 diploma course in a different way.

28 I think we have done a lot of thinking  
29 as to what this different way is but the changes of  
30 medical practice and the changes that we are going







1 through probably at the moment with insurance and so on  
2 in this province, make it almost impossible for us to  
3 see today what even we are going to do tomorrow but we  
4 all know we need an upgraded professional nurse and an  
5 upgraded second-level nurse and whether she be part of  
6 a hospital program or part of an independent program,  
7 we cannot decide upon that at the moment. Does that  
8 answer your question, Miss Girard?

9 COMMISSIONER GIRARD: Not quite. My  
10 question was, what are we now going to do with our  
11 hospital schools as they are now? Are we going to keep  
12 them that way? Are we going -- what tangible things  
13 are we doing in our hospital schools to make them what  
14 they should be or what we would want them to be?

15 MISS LAMONT: Well, I would hope that  
16 the upgrading of the Canadian nurses program of school  
17 improvement will bring an overall improvement gain.  
18 The studying of nursing services in a joint way, again  
19 should improve both the patient care and it will neces-  
20 sarily improve the schools but to answer your question  
21 as to whether or not we are going to abolish the hospital  
22 school or not I don't think we have made this statement.

23 COMMISSIONER GIRARD: You mean we  
24 haven't made the statement that we are going to abolish  
25 them?

26 MISS LAMONT: No.

27 COMMISSIONER GIRARD: I think that  
28 will reassure a lot of people.

29 MISS LAMONT: That is the direct  
30 answer.

through probably at the moment with insurance and so on in this province, make it almost impossible for us to see today what even we are going to do tomorrow but we all know we need an upgraded professional nurse and an upgraded second-level nurse and whether she be part of a hospital program or part of an independent program, we cannot decide upon that at the moment. Does that answer your question, Miss Girard?

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1 THE CHAIRMAN: On that point, how many  
2 nurses are you graduating from the university school  
3 per year now?

4 MISS REIMER: We have only one basic  
5 course at this time, sir, and we had our first graduates  
6 from that school last year, five. That is five nurses  
7 graduated from a basic university course, a basic course.

8 THE CHAIRMAN: Now there are expansions?

9 MISS REIMER: Another course will open  
10 in the Fall, yes.

11 THE CHAIRMAN: What would be the number  
12 to be graduated from these courses when they are developed?  
13 How many per year?

14 MISS REIMER: The university program  
15 in existence now is a new program, a more or less  
16 experimental program, so it is really difficult for us  
17 to say how quickly it will grow, and a new program which  
18 is to open this coming Fall will also be an experimental  
19 program.

20 I mean, they will need a few years to  
21 get started, so it is very difficult to say how many we  
22 will have per year from these schools.

23 THE CHAIRMAN: Are you speaking in terms  
24 of five, ten, twenty, thirty or a hundred or two hundred?  
25 What is the reasonable objective that is being held out  
26 at the moment?

27 MISS GAGNON: I don't know whether I  
28 can give you exact figures, but as Miss Reimer stated,  
29 the new program that will begin in September 1962, the  
30 school authorities plan to admit about ten students.



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1 Naturally, there will be a number of  
2 students who will leave before the end of the course.  
3 Will all of these students finish the four-year course?  
4 Will they all receive a diploma at the end of the four-  
5 year period? That is the question.

6 However, we believe that the school  
7 authorities will accept ten students for the first year.  
8 We don't know whether they will accept 20 or more for  
9 the following years. We don't know. We do hope that  
10 several more candidates will be drawn.

11 Unfortunately, I cannot say any more.  
12 We hope to have 10 to begin with.

2 13 THE CHAIRMAN: How many nurses do you  
14 have now per year in all the schools?

15 MISS REIMER: Sir, we license about  
16 1,250 graduates per year of our own graduates, graduates  
17 from basic schools of nursing.

18 THE CHAIRMAN: Is it fair then for me  
19 to relate that figure, plus the augmentation that would  
20 be required with an increased population in the next 50  
21 years, that these are the people that you all want  
22 graduated from a university at this 50-year period?

23 MISS MERLEAU: No.

24 THE CHAIRMAN: All right then, what  
25 proportion have you in mind as being the ideal situation,  
26 university graduates, and hospital schools of nursing  
27 graduates?

28 MISS MERLEAU: Well, I believe, sir,  
29 that we are not thinking so much in numbers as of quality.

30 THE CHAIRMAN: Well, you said that you



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2 students who will leave before the end of the course.  
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9 the following years. We don't know. We do hope that  
10 several more candidates will be drawn.  
11 Unfortunately, I cannot say any more.

12 We hope to have 10 to begin with.  
13 THE CHAIRMAN: How many times do you  
14 have now per year in all the schools?

15 MISS REIMER: Sir, we license about  
16 1,500 students per year of our own students, graduates  
17 from local schools of nursing.

18 THE CHAIRMAN: Is it fair to say  
19 to make that figure, after the suggestion that would  
20 be required for an increased population in the next 25  
21 years, that these are the people that you all want  
22 graduated from a university at this 4-year period?

23 MISS REIMER: No.  
24 I would like to see you in kind as being the ideal situation,  
25 university graduates, and hospital schools of nursing.

26 MISS REIMER: Well, I believe, sir,  
27 that we are not training as much in numbers as of quality.  
28 THE CHAIRMAN: Well, you would let you





1 were going to do something in the future.

2 MISS MERLEAU: Well, it is - we can  
3 raise another question. First there is the matter of  
4 the recruiting. Then there is the question of preparing  
5 candidates. We will have more candidates if the prepara-  
6 tion of girls is adequate, in order to enable them to be  
7 admitted to the university schools, but up to now we  
8 haven't reflected on the actual number of such schools  
9 that will appear in 10 or 20 years.

10 THE CHAIRMAN: But you mentioned a  
11 figure of 25%.

12 MISS MERLEAU: Well, these were in  
13 basic schools, but in the province, from the point of  
14 view of university schools, this experiment has only  
15 just begun.

16 MISS REIMER: Sir, regarding numbers,  
17 in paragraph 33 we have some projected population figures  
18 and we say that to maintain the present ratio of nurses  
19 to population we give a number there that we would  
20 require, but we also say that we might be able to attain  
21 this number but the problem is the quality of the nurse  
22 that we prepare we believe is more important than the  
23 numbers and we hope that in our hospital schools, as well  
24 as university programs, that the quality of the nursing  
25 education will improve and that we will be able to  
26 prepare a better nurse.

27 We must prepare a nurse who is better  
28 qualified to meet the nursing needs of the patient and  
29 we have really not been concerned so much with numbers  
30 as with qualifications and quality.



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THE CHAIRMAN: But you mentioned a

figure of 25%.

MRS. MCKINLEY: Well, these were in

basic schools, but in the province, from the point of view of university schools, this experiment has only just begun.

in 1950? If we have some projected population figures and we say that to maintain the present ratio of nurses to population we give a number there that we would require, but we also say that we might be able to attain this number but the problem is the quality of the nurse that we require we believe is more important than the number and we hope that in our hospital schools, as well as university programs, that the quality of the nursing education will improve and that we will be able to prepare a better nurse.

We must prepare a nurse who is better qualified to meet the nursing needs of the hospital and we have really not been concerned so much with nurses as with qualifications and quality.



1 THE CHAIRMAN: Well, I don't want to  
2 pursue the point to anyone's embarrassment but you  
3 stated as your objective that in the period of whatever  
4 that 50 years, or whatever you wanted to state, that  
5 this is where you were going to go. You were going to  
6 graduate them all in the university schools.

7 MISS REIMER: Sir, I didn't state that  
8 as an objective. You asked me, we haven't worked this  
9 out in terms of years, but personally ---

10 THE CHAIRMAN: Oh, I am not holding  
11 you to 50 years, but you are just saying that in a  
12 foreseeable time.

13 MISS REIMER: In a foreseeable time.  
14 Well, I know, sir, from experience ---

15 THE CHAIRMAN: Not that I am going to  
16 foresee 50 years, no.

17 MISS REIMER: But I think that this  
18 could develop. I am saying I, because I don't want to  
19 embarrass my officers. I think it could develop more  
20 rapidly than we perhaps realize because I had to do with  
21 the establishment of a university school in a country  
22 where there were no nurses and they have got a couple of  
23 hundred nurses now, and that is not so long ago.

FF/PB/dpw 24 So, I believe in this country there  
25 are even greater possibilities but we believe we have to  
26 make a beginning first and make a good beginning and you  
27 can't make a good beginning if you are going to begin  
28 with young women who are not qualified for university  
29 programs.

30 Also, we don't have the teachers, so



THE CHAIRMAN: Well, I don't want to

leave the point to anyone's embarrassment but you

stated as your objective that in the period of which ever

that 50 years, or whatever you wanted to state, that

this is where you were going to go. You were going to

graduate them all in the university schools.

as an objective. You asked me, we haven't worked this

out in terms of years, but personally ---

THE CHAIRMAN: Oh, I am not holding

you to 50 years, but you are just saying that in a

reasonable time,

MISS BELMONT: In a reasonable time.

Well, I know, sir, from experience ---

THE CHAIRMAN: Not that I am going to

foresee 50 years, no.

MISS BELMONT: But I think that this

could develop. I am saying I, because I don't want to

emphasize my objectives. I think it could develop more

rapidly than we perhaps realize because I had to do with

the establishment of a university school in a country

where there were no nurses and they have got a couple of

trained nurses now, and that is not so long ago.

So, I believe in this country there

are even greater possibilities but we believe we have to

make a beginning first and make a good beginning and you

can't make a good beginning if you are going to begin

with people who are not qualified for university

degrees.



1 we will have to begin and make a good sound beginning  
2 and then eventually it will grow more rapidly than we  
3 have now proposed.

4 THE CHAIRMAN: Do you want to state  
5 what is your objective?

6 MISS REIMER: Sir, we have no objective  
7 in figures.

8 THE CHAIRMAN: Not in figures, in  
9 principle; or have you one? If you haven't one, that's  
10 it.

11 MISS REIMER: We have an objective.  
12 You mean, sir, the objective for nursing education?

13 THE CHAIRMAN: Where you are going to  
14 educate nurses.

15 MISS REIMER: Where?

16 THE CHAIRMAN: Yes.

17 MISS REIMER: Well, our objective is  
18 to prepare the nurses who will be able to meet...

19 THE CHAIRMAN: My question, if you don't  
20 mind, is where?

21 MISS REIMER: Where?

22 THE CHAIRMAN: Where.

23 MISS REIMER: Well, where-- all right,  
24 we now have one basic university program. Next Fall  
25 another one will be opened, and we hope, in another  
26 couple of years, another one, but we hope that additional  
27 programs, university programs, will begin in this province  
28 and we are looking towards those university programs to  
29 develop quite rapidly once they do begin. In the mean-  
30 time...







1 THE CHAIRMAN: Would you mind if I stop  
2 you there. Is it your view that over a period of years  
3 these university programs will develop to the extent  
4 that you will graduate 1,000 or 1,200 nurses a year?

5 MISS REIMER: That is quite a high  
6 figure.

7 THE CHAIRMAN: Is that your objective?

8 MISS REIMER: We haven't expressed our  
9 objective in that way, sir, because we think it is quite  
10 difficult to do that.

11 THE CHAIRMAN: Express it in your own  
12 way, if you want to.

13 MISS REIMER: We will be very happy in  
14 this province when we have two sound university programs  
15 established. We will be happier still when we have  
16 three and perhaps four, but it is not so easy to establish  
17 university programs.

18 We need teachers, educators, nurse  
19 educators and consequently our objective is to give  
20 every support to new university programs that will be  
21 established, but we don't say that we - we can't possibly  
22 say we would expect 1,000 nurses to be graduated from  
23 university programs in a certain number of years. I  
24 don't think we could say that.

25 That is why we say we will continue  
26 with our hospital schools of nursing and improve them  
27 in order to prepare nurses.

28 COMMISSIONER GIRARD: Before abandoning  
29 the subject which has been under discussion, couldn't  
30 we try to formulate, to some extent, the objective of



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That is why we say we will continue

with our hospital schools of nursing and improve them

in order to prepare nurses.

COMMISSIONER CLARK: Before abandoning

the subject which has been under discussion, couldn't

we try to formulate, to some extent, the objective of



1 the Association? Would it not be at this stage to  
2 improve, as much as possible, our nursing schools, the  
3 nursing schools, and to bring them up to the level at  
4 which they should be if there were an accreditation  
5 program and at the same time develop university schools  
6 at the most accelerated rate possible?

7 Can you see a small number each year  
8 of these nurses with university diplomas, university  
9 graduates but with a view to increasing that number,  
10 but jointly with hospital nurses? Would that be a  
11 summation of the expression of the objectives of the  
12 Association at this stage?

13 MISS MERLEAU: I think that is exactly  
14 what we stated in our brief. It is understood that we  
15 hope one day our nurses will graduate from universities,  
16 but not at this time. We want to continue our schools,  
17 with the hope of having accreditation of our nursing  
18 schools at some stage and with the university program  
19 to be accelerated as much as possible so as to aim at  
20 something, but we can't say today what number we think  
21 will finally wind up as university people.

22 COMMISSIONER GIRARD: Well, in relation  
23 to our nursing school you say at paragraph 65:

24 "Another very apparent reason for the  
25 shortage of teachers is that a large  
26 percentage of students entering  
27 schools of nursing have had only the  
28 minimum educational qualifications  
29 and did not qualify for entrance to  
30 the post-basic nursing courses in the







1 universities."

2 Together with a lack of teachers this  
3 obviously holds back the progress of the schools of  
4 nursing. Would you be prepared to speak on other  
5 courses, which, at the present time, constitute obstacles  
6 to improving the hospital schools since it is the hospital  
7 schools that are, so to speak, the spinal column of the  
8 whole structure at this time?

9 MISS MERLEAU: Miss Gagnon, could you  
10 answer that?

11 MISS GAGNON: Well, Mr. Chairman and  
12 madam, I think that at present the greatest effort we  
13 are making is to attempt to improve the level of basic  
14 general education of the students accepted in nursing  
15 schools. I think it is one of the first steps we must  
16 take in accepting any nursing school candidates, to put  
17 a level of education and instruction, which opens the  
18 door to them for post-graduate study.

19 We can already foresee the numbers who  
20 may perhaps go on to teaching.

21 COMMISSIONER GIRARD: I see on page 14,  
22 you mentioned 15% had Grade 12:

23 "While schools of nursing are having  
24 more and better applicants the number  
25 of candidates with the desired qualifi-  
26 cations does not meet the need at all.  
27 Of 2,500 students admitted in 1961 15%  
28 had Grade 12 education or its equivalent,  
29 35% had junior matriculation but 50%  
30 had only the minimum qualifications



and the other.

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courses, which, at the present time, constitute obstacles

to improving the hospital schools since it is the hospitals

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whole education at this time?

MISS MERRILL: Mrs. Gagnon, could you

answer that?

MISS GAGNON: Well, Mr. Chairman and

members, I think that at present, the greatest effort we

are making is to attempt to improve the level of basic

general education of the students accepted in nursing

schools. I think it is one of the first things we must

take to improve any nursing school curriculum, to put

a level of education and instruction, which enables the

graduates to go on for post graduate study.

We can already foresee the number who

may be able to go on to teaching.

COMMISSIONER GIBBS: I see on page 14,

you mentioned 150 had Grade 12.

While schools of nursing are having

more and better opportunities the number

of candidates with the desired qualifi-

cations does not meet the need at all.

Of 2,500 students admitted in 1961 150

had Grade 12 and 150 had the equivalent.

150 had the two year preparation but 500

had only the minimum qualifications.





1 according to the Act of High School  
2 Leaving."

3 Can you indicate the difference between  
4 junior matriculation and Grade 11?

5 MISS MERLEAU: I wonder if we could ask  
6 Miss Lamont to answer that question because the difference  
7 between junior matriculation and Grade 11 is not obvious  
8 in the French system. That note is to be added for the  
9 English-speaking.

10 MISS LAMONT: The difference between  
11 high school leaving, Grade 11 and junior matriculation  
12 is one of percentage. The high school leaving, the  
13 student with high school leaving may take eight papers  
14 and get high school leaving from Grade 11.

15 To enter university she must have  
16 junior matriculation, which is ten papers and for the  
17 English language schools of nursing we have required  
18 ten papers and four compulsory subjects and an average  
19 of 65%.

20 This permits the student's admittance  
21 to McGill. I think our big problem in the province for  
22 the English is perhaps the fact we don't have, in most  
23 of our high schools, the senior matriculation year.

24 These students are quite young, 17,  
25  $17\frac{1}{2}$ , when they leave school. When you try to get them  
26 to take the senior year which gives them a little more  
27 maturity, there is only one high school in Montreal  
28 that teaches it.

29 I think the French language schools  
30 don't have the same trouble getting the senior matriculation



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MISS MONTGOMERY: I wonder if we could ask

Miss Jansen to answer that question because the difference

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don't have the same problem. Getting the senior matriculation



1 year, at least in the cities; but in the regional areas  
2 sometimes they can't get any science in their programs  
3 and can't even get Grade 11, so we are very much handi-  
4 capped in keeping our students in school a little longer  
5 and having a better applicant for nursing.

6 This accounts for the percentage who  
7 are admitted with just high school leaving and not  
8 matriculation.

9 COMMISSIONER GIRARD: So we still have  
10 the problem of having to require better education  
11 among the girls who wish to enter the profession so  
12 when they receive their diploma they may be prepared to  
13 continue with their studies. That is what I want to  
14 know.

15 On one hand you have stated the diffi-  
16 culty both on the French and on the English sides of  
17 having sufficient resources so that the girls can take  
18 their senior matriculation more or less anywhere in the  
19 province, because there are not enough schools where  
20 they can obtain senior matriculation.

21 Does this problem, since it is a problem  
22 of education - has this problem been brought to the  
23 attention of the Department of Public Education by the  
24 Association?

25 MISS MERLEAU: Miss Gagnon could  
26 answer on this point.

27 MISS GAGNON: Yes, madam, the Department  
28 of Public Education has been informed of the problem  
29 and, as you know, we are also having a rethinking on  
30 education in the Province of Quebec and we hope that





1 year, or less, in the class; but in the regional areas  
 sometimes they can't get any science in their programs  
 and can't even get Grade 11, so we are very much handicapped  
 in keeping our students in school a little longer  
 and having a better applicant for nursing.

This accounts for the percentage who

are satisfied with their high school leaving and not

in the region.

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attention of the Department of Public Education by the

MISS MARRAS: Miss Gagnon could

answer on this point.

MISS GAGNON: Yes, madam, the Department

of Public Education has been informed of the problem

and, as you know, we are also having a rethinking of

education in the Province of Quebec and we hope that



1 soon there will be something forthcoming there. If I  
2 may I would like perhaps to add that for about three or  
3 four years, I believe, we have been a little - we have  
4 required a little more. We have required more from the  
5 directors of nursing schools. We have insisted, we have  
6 tried to convince them to select candidates with higher  
7 education, the twelfth grade, and we see now nursing  
8 schools where 50% of the students have a level of Grade  
9 12, so we think that even by having stronger requirements,  
10 more severe requirements, it will make the career more  
11 interesting for the girls to take their studies.

12 COMMISSIONER GIRARD: This comes to  
13 the question which you have dealt with in the brief  
2 14 also, of the selection of candidates for the profession,  
15 where you stated that the profession had to be made not  
16 only attractive by outside things such as fine houses  
17 and so forth as you mentioned, but also by showing the  
18 deeper and more scientific and intellectual side of the  
19 profession. Would you like to say something on that  
20 point? What are the immediate objectives or the future  
21 objectives you propose in that connection because Grade  
22 12 - you can't require - you can require it gradually,  
23 an increase, but you can't require it absolutely because  
24 it would greatly reduce the number of candidates.

25 How is it possible to get more interest  
26 on the part of the candidates in the more serious side  
27 of the profession, as you mentioned in the brief?

28 MISS MERLEAU: Could I have Miss Lamarre  
29 answer that question?

30 MISS LAMARRE: To develop the







1 intellectual and social side we are saying in our brief,  
2 I think, first, that the curricular or basic courses  
3 in our hospitals could also be, the selection could  
4 be elaborated, the scientific side and the humanities  
5 side.

6 I think also from the social point of  
7 view the doors of our schools are open wider to the  
8 community and recognition of the Association to each  
9 of these schools has been, and we find now - we are  
10 already finding certain progress in this matter.

11 COMMISSIONER GIRARD: The Chairman was  
12 wondering about a question which I will put to you: is  
13 it possible to give a tangible reply as to the success  
14 or degrees of success in the various candidates who have  
15 begun the course after the eleventh grade or those who  
16 begin after twelfth grade? Is there anything tangible  
17 there?

18 MISS MERLEAU: I will ask Miss Lamont  
19 to answer that.

20 MISS LAMONT: Individuals differ. Some-  
21 times you can't make a statement accurately, although a  
22 student who has one year more academic training and  
23 more science will do a better job in the basic program.  
24 The answer is yes.

25 THE CHAIRMAN: Does a pattern emerge  
26 from year to year?

27 MISS LAMONT: Yes.

28 COMMISSIONER GIRARD: Sister Décary, do  
29 you wish to speak to this point? Have you a number of  
30 Grade 12 students?





1                               SISTER DECARY: We have several students  
2 who have their twelfth grade, and in accordance with  
3 the reports we have in our school we can say that these  
4 students are better adapted to the requirements of the  
5 profession, both intellectually - well, I can't say  
6 devotionally - in the department, they react better in  
7 the class and they understand better generally.

8                               We would really wish to have 100% of  
9 our students with twelfth grade.

10                            COMMISSIONER GIRARD: I think if they  
11 are requiring Grade 12 rather more, in the case of 12,  
12 perhaps it is because we feel they will have better  
13 personalities towards the patient and because they  
14 think we will understand more of the basic procedure,  
15 they will know better the whys and wherefores of the  
16 treatment, they will be in a better position to judge  
17 the requirements of the patient and themselves to  
18 develop a plan of work with the patient and thereby to  
19 get better results. Do you agree with that opinion as  
20 to what we expect of the students, to have that stronger  
21 basis?

22                            SISTER DECARY: I think you have put  
23 your finger on it, Miss Girard.

24                            COMMISSIONER GIRARD: Now, in the  
25 summary of the main points in the brief you note under 5,  
26 conditions of employment to be compared favourably with  
27 other professions. What do you say about how we are  
28 now situated in the Province of Quebec from the point  
29 of view of what is described under No. 5, from the point  
30 of view of conditions of employment?







1 MISS MERLEAU: Sister Décary, do you  
2 wish to answer on that point?

3 SISTER DÉCARY: As to the question of  
4 the conditions of employment at this time necessarily  
5 we are subject to the hospitalization insurance plan,  
6 but we think in point of salaries granted to the hospital,  
7 they are perhaps adequate, but they are not equal to  
8 those of other areas that nurses have in industry or  
9 elsewhere.

10 That may be some source of frustration  
11 and discontent, and often for departure to other  
12 employment or occupation.

13 COMMISSIONER GIRARD: I think the  
14 Chairman had a question he wished to put to you. I  
15 think this would probably be the time for it.

16 THE CHAIRMAN: What do you think of  
17 the alliance with the Union of Nurses? What role would  
18 the Association play in that field?

19 MISS MERLEAU: I wonder, Mr. Chairman,  
20 if I would be permitted to ask whether Miss Flanagan  
21 is in the room because it is she who is our co-convenor  
22 on our Committee of Labour Relations?

23 THE CHAIRMAN: The reason I put this  
24 question is that in your brief you speak of the profession  
25 of nursing and you speak of the level of the profession,  
26 the professional level. Can the profession be a union?

27 MISS MERLEAU: Well, it seems to me  
28 latterly I think I have read it in the newspapers that  
29 there is already talk of professional unions, but when  
30 you mention the alliance of nurses, I think you mean the







1 union which is known as L'Alliance des Infirmières of  
2 which some nurses are members and you would like to  
3 know what we think of that as an Association.

4 Well, you have got me in a corner,  
5 Mr. Chairman.

PMcH/dpw

6 But I think that everyone is free to  
7 belong to any body he wishes to except if the nurses  
8 wish to be members of a union they are free to do so.  
9 Now, I think you have not asked me for my personal view  
10 but as an Association this is what we think: our nurse  
11 is free to continue.

12 THE CHAIRMAN: Thank you.

13 COMMISSIONER GIRARD: Miss Merleau,  
14 would you wish, in relation to the Chairman's question,  
15 to speak of the role that the physician might play as a  
16 negotiating agent?

17 MISS MERLEAU: We have, as a negotiating  
18 agent under Section 17 of our Statutes, the privilege of  
19 negotiating but it is at district level only. The  
20 Association is divided into ten districts which comprise  
21 the electoral districts of the Province of Quebec but  
22 if it wished that the district negotiate for them the  
23 nurse must make the request to the district of their  
24 Association. Does that answer the point?

25 COMMISSIONER GIRARD: Now, there is one  
26 question here that has not been dealt with in your  
27 brief but that I have taken the liberty of raising more  
28 or less throughout Canada because I consider it most  
29 appropriate and it is that of the standards applicable  
30 to nursing in hospitals.





1 In a number of places in Canada we have  
2 been told of hospitalization insurance; we have been  
3 told of the manner in which it was preceded in order to  
4 determine the number of nurses in the hospital. I have  
5 found out that almost everywhere one still spoke of a  
6 percentage of 3.4 and 3.5 hours of service and everywhere  
7 they seem to be attached to that as something entirely  
8 scientific. What is your view of that? Would anyone  
9 wish to say what has been done in the Province of Quebec?

10 MISS MERLEAU: I think Sister Décary  
11 could give you an answer.

12 SISTER DÉCARY: In the Province of  
13 Quebec we have certainly made some investigations of  
14 this; it has been published in several hospitals as a  
15 result of inquiries in various hospitals and we have  
16 found after daily study, and I might say, month after  
17 month, we have concluded that 4.5 might be more appro-  
18 priate for medicine, surgery and general medicine.

19 6.5% is for paediatrics. This also  
20 depends on our individual hospitals. We think it is  
21 very difficult to establish standards, absolute standards,  
22 for all hospitals. This is not, as is indicated in our  
23 preparation of this study we have made and it is indicated  
24 that attention must be given to the extent of the  
25 hospital, that is, the size and the type of patient also.

26 We do think that is high time to  
27 establish standards which may be more or less identical  
28 everywhere to eliminate from the work of the nurse such  
29 works as food, cleaning and sort of housework and that  
30 sort of thing. That is why we, at this time, cannot



In a number of places in Canada we have been told of hospitalization insurance; we have been told of a number of places in which it was provided in order to relieve the number of cases in the hospital. I have found out that almost everywhere one still spoke of a percentage of 2.5 and 3.5 hours of service and everywhere they seem to be attached to that as something entirely scientific. What is your view of that? Would anyone wish to say what has been done in the Province of Quebec?

What is your answer?

SIR: In the Province of

Quebec we have certainly made some investigations of this; it has been published in several hospitals as a result of inquiries in various hospitals and we have found it as daily study, and I might say, month after month, we have concluded that 4.5 might be more appropriate for the treatment, surgery and general medicine.

6.5% is for paediatrics. This also

depends on our individual hospitals. We think it is very difficult to establish standards, absolute standards for all hospitals. This is not, as is indicated in one organization of this study we have made and it is indicated that it is not to give to the extent of the

hospital, but in the same way the type of patient also.

We do know that in some cases

established standards which may be more or less identical everywhere so that from the point of the nurse such were as food, clothing and sort of housework and that

some of them. That is why we, at this time, cannot



1 reach special standards, we cannot make a standard and  
2 say it must be that because it is individual to each  
3 hospital at this stage. In the future we may come to  
4 standards which may be fairly acceptable. Does this  
5 answer the point?

6 COMMISSIONER GIRARD: In order to  
7 inform the authorities responsible for hospitalization  
8 plans more or less everywhere, is it your view that we  
9 need research in that field?

10 SISTER DÉCARY: I think we have to have  
11 research in the field, it would not be superfluous; I  
12 think even it would be indicated.

13 COMMISSIONER GIRARD: Another question  
14 which has not been dealt with in the brief which I  
15 would like to deal with here, if I may, and which is a  
16 present question in Canada and that is the question of  
17 male nurses.

18 They talked about the lack of nurses  
19 and everywhere the related professions ask us "What  
20 about male nurses since we have not enough female nurses?"  
21 I know there is a special case in Quebec but what are we  
22 doing to get around that?

23 MISS MERLEAU: For the present nothing  
24 is being done because you know there is a law in the  
25 Province of Quebec or rather a statute in the Association  
26 and it would be necessary to go back to the Legislature  
27 to have an amendment adopted.

28 At the present time we are intending  
29 to do so but we do not think it is mature at this stage.  
30 Male nurses, as you know, have formed an association in







1 Quebec and intend to do the same thing in Montreal but  
2 at present that is all that exists.

3 COMMISSIONER GIRARD: We are not against  
4 the male nurses, are we?

5 MISS MERLEAU: No, certainly not.

6 SISTER DÉCARY: We have male nurses,  
7 we have some in our hospital and we appreciate their  
8 services very much; if we could have more male nurses  
9 we would certainly retain their services. We have  
10 offered our hospital in surgery and medicine to serve  
11 these young students from the Hospital of Mercy to go  
12 and do six months service in medicine and surgery and  
13 we would be very happy to receive them.

14 COMMISSIONER GIRARD: You may have  
15 read recently in the papers that a neighbouring province  
16 has established a college, the advantages that they are  
17 to receive from this college we already have by our  
18 active incorporation.

19 There is one advantage that they have  
20 that we do not have and this is that this college  
21 brings in nursing assistants under the aegis of the  
22 Association.

23 Now, what are you doing about the  
24 Province of Quebec along this line?

25 MISS MERLEAU: I think in the brief we  
26 have said something about this point. The Association  
27 is of the view that this exists and there is a requirement  
28 for assistants, whatever should be prepared for the  
29 exercise of a well-defined function and subject to legis-  
30 lation.





1 COMMISSIONER GIRARD: Draft legislation?

2 MISS MERLEAU: We have not decided that  
3 as to how it should be settled yet.

4 COMMISSIONER GIRARD: Now, I have more  
5 or less exhausted the list of questions which I proposed  
6 to put to you. Are there any points in the brief on  
7 which I have not dwelt and which you would like to  
8 speak, to give further expansion on?

9 MISS MERLEAU: For my part I do not  
10 think there is anything.

11 COMMISSIONER GIRARD: Something that  
12 has not been elaborated upon?

13 MISS MERLEAU: No.

14 THE CHAIRMAN: Dr. Van Wart?

15 COMMISSIONER VAN WART: No questions.

16 COMMISSIONER McCUTCHEON: No questions.

17 COMMISSIONER BALTZAN: No questions,  
18 only to say that time is short and experience is long  
19 and we have had wonderful experience.

20 COMMISSIONER FIRESTONE: Miss Merleau,  
21 is there a shortage of nurses in the Province of Quebec?

22 MISS MERLEAU: I do not know whether  
23 we should say a shortage, is there really a shortage or  
24 is there perhaps in the way we utilize the nurses that  
25 we have?

26 COMMISSIONER FIRESTONE: Is there a  
27 shortage of nursing aids in the Province of Quebec?

28 MISS MERLEAU: That we do not know.

29 SISTER DECARY: I will say by experience,  
30 according to my experience, we do not have enough





COMMISSIONER GIBBARD: Brief legislation?

MISS MERLEAU: We have not decided that as to how it should be settled yet.

COMMISSIONER GIBBARD: Now, I have more or less extracted the first of questions which I proposed to put to you. Are there any points in the brief on which I have not dwelt and which you would like to speak, to give further explanation on?

MISS MERLEAU: For my part I do not think there is anything.

COMMISSIONER GIBBARD: Something that has not been elaborated upon?

MISS MERLEAU: No.

THE CHAIRMAN: Dr. Van Wart?

COMMISSIONER VAN WART: No questions.

COMMISSIONER MONTGOMERY: No questions.

MISS MERLEAU: I do not know whether there is a shortage of nurses in the Province of Quebec?

MISS MERLEAU: I do not know whether we should say a shortage, is there really a shortage or is there perhaps in the way we utilize the nurses that we have?

COMMISSIONER MONTGOMERY: Is there a shortage of nursing staff in the Province of Quebec?

MISS MERLEAU: That we do not know.

MISS MERLEAU: I will say by experience, according to my experience, we do not have enough



1 trained aids. There are a good number of aids but  
2 trained aids are certainly lacking.

3 COMMISSIONER FIRESTONE: What could be  
4 done to encourage more young girls to enter the nursing  
5 profession and be persuaded to have perhaps more people  
6 taking both training courses, one for a fully-trained  
7 registered nurse and, secondly, for nursing aids?

8 MISS MERLEAU: I would ask Miss Lamont  
9 to answer that.

10 MISS LAMONT: On the nursing aid level  
11 we have to have organized courses under independent  
12 auspices or hospitals. In hospitals we have some very  
13 good programs and we have independent programs but not  
14 enough.

15 I think if this were organized and  
16 advertised there would probably be enough young ladies  
17 in the province to go into the nursing aid program.

18 I think we have been mentioning many  
19 ways of interesting the right type of young woman in  
20 nursing and that is, there should be basic functions  
21 when we get her, there should be a proper course in the  
22 University or at the same level; one which stimulates  
23 her interest and trains her to meet the needs today.  
24 I suppose there are other means; financial support is  
25 sometimes considered a necessity and this we have had  
26 in most of our schools.

27 The students are not reimbursed or  
28 should they give any financial help, any adequate finan-  
29 cial help to go into nursing.

30 COMMISSIONER FIRESTONE: Can you suggest

trained aids. There are a good number of aids but

COMMISSIONER FIRESTONE: What could be

done to encourage more young girls to enter the nursing profession and be persuaded to have perhaps more people taking both training courses, one for a fully-trained registered nurse and, secondly, for nursing aids?

MISS LAMONT: On the nursing aid level

we have to have organized courses under independent auspices or hospitals. In hospitals we have some very good programs and we have independent programs but not

I think if this were organized and supervised there would probably be enough young ladies in the province to go into the nursing aid program. I think we have been mentioning many

ways of increasing the type of young woman in nursing and that is, there should be basic functions when we see her, there should be a proper course in the university or at the same level; one could stimulate her interest and train her to meet the needs today. I suggest that we have a program; financial support is sometimes considered a necessity and that we have had in mind of our society.

The students are not interested in that they give me financial help, any economic plan- that will go into nursing.

COMMISSIONER FIRESTONE: Can you suggest





1 any specific financial incentives or arrangements of  
2 financial support that would encourage more young ladies  
3 to enter the nursing profession?

4 MISS LAMONT: I do not know if I can  
5 speak for all the nurses but I think the education of  
6 the nurses should be supported in the same way as any  
7 school that we might know of all the things we are  
8 trying to do and get the education sound and the right  
9 students into this course.

10 would be given? COMMISSIONER FIRESTONE: By that you  
11 mean bursaries, scholarships? What do you have in mind  
12 specifically applicable to the nurses?

13 MISS LAMONT: I suppose to start with  
14 it would be bursaries and scholarships, more of these  
15 at the present moment would help us prepare more teachers  
16 because we have not nearly enough and have not enough  
17 support for them.

18 COMMISSIONER FIRESTONE: Would you like  
19 to see nurses do more graduate work?

20 MISS LAMONT: They must do more graduate  
21 work, the needs are there.

22 COMMISSIONER FIRESTONE: How would you  
23 encourage them to do it?

24 MISS LAMONT: I suppose remuneration,  
25 once they have done this, would be one way. In other  
26 words, all the salaries should be in keeping with other  
27 highly-skilled people.

28 COMMISSIONER FIRESTONE: If you were  
29 to persuade the nurses to undertake more graduate work  
30 would you feel part of their graduate studies would be



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COMMISSIONER WILKINSON: If you were  
to prepare the nurses to undertake more graduate work  
would you feel part of their graduate studies would be



1 to familiarize themselves with the sort of tasks which  
2 the medical profession is turning over to them to an  
3 increasing extent?

4 MISS LAMONT: I would say yes, they  
5 should be taking on some of the duties which the  
6 medical profession has not the time to do just as they  
7 should be giving up some of the tasks which are not  
8 their responsibility any more.

9 COMMISSIONER FIRESTONE: And the training  
10 would be given at a graduate level?

11 MISS LAMONT: Yes, it must be in a  
12 university, you mean?

13 COMMISSIONER FIRESTONE: I am being  
14 guided by yourself, at whatever level you wish; but I  
15 take it if nurses are to take on added responsibility  
16 which would require added skills, they have to learn  
17 this somewhere?

18 MISS LAMONT: That is right.

19 COMMISSIONER FIRESTONE: Your suggestion  
20 is they would study this and acquire experience at a  
21 graduate level; is that your suggestion?

22 MISS LAMONT: Yes.

23 COMMISSIONER FIRESTONE: That would  
24 cover one or two years?

25 MISS LAMONT: That is something which  
26 would be for the time being, it would depend on whether  
27 it was a degree course they were taking as to how much  
28 time they spent.

29 COMMISSIONER FIRESTONE: What order do  
30 you have in mind? An extra year or two?





1. The first thing I noticed when I came to the  
2. the medical profession is that it is a very  
3. interesting and varied profession.

4. I have found that the medical profession is a very  
5. interesting and varied profession.

6. I have found that the medical profession is a very  
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31. interesting and varied profession.



1 MISS LAMONT: Well, the diploma student  
2 who comes into the university on a post-graduate level  
3 at the present moment must spend two years to get a  
4 degree or one year, which gives her a diploma.

5 COMMISSIONER FIRESTONE: And would you  
6 offer these nurses financial incentives and scholarships  
7 at the graduate level as well to persuade them to come?

8 MISS LAMONT: Yes, this is a great  
9 thing now to prepare the lower level.

10 COMMISSIONER FIRESTONE: If I make  
11 myself clear, I am talking of the graduate level and  
12 you would offer them scholarships and bursaries at the  
13 graduate level?

14 MISS LAMONT: Yes.

15 COMMISSIONER FIRESTONE: What amount  
16 would you consider an appropriate scholarship to enable  
17 a nurse to spend a year of graduate studies at a univer-  
18 sity?

19 MISS LAMONT: I would suppose it would  
20 depend on which university. I think we figure about  
21 \$2,000 is about the minimum for one academic year at  
22 McGill.

23 COMMISSIONER FIRESTONE: That would  
24 include board and fees and tuition, etc?

25 MISS LAMONT: Yes.

26 COMMISSIONER FIRESTONE: And how many  
27 such Fellowships or scholarships at the graduate level  
28 would you consider appropriate for the Province of  
29 Quebec initially?

30 MISS LAMONT: I could not say.



MISS LAMONT: Well, the diploma student who comes into the university on a post-graduate level at the present moment must spend two years to get a degree or one year, which gives her a diploma.

COMMISSIONER FIRESTONE: And would you offer these courses financial incentives and scholarships at the graduate level as well to persuade them to come?

MISS LAMONT: Yes, this is a great thing now to prepare the lower level.

COMMISSIONER FIRESTONE: If I make myself clear, I am talking of the graduate level and you would offer them scholarships and bursaries at the graduate level?

MISS LAMONT: Yes.

COMMISSIONER FIRESTONE: What amount would you consider an appropriate scholarship to enable a person to spend a year of graduate studies at a university?

MISS LAMONT: I would suppose it would depend on which university. I think we figure about \$2,000 is about the minimum for one academic year at the graduate level.

COMMISSIONER FIRESTONE: And how many would you consider appropriate for the Province of Ontario?

MISS LAMONT: I could not say.





1 COMMISSIONER FIRESTONE: Would you  
2 start off with five or ten or fifty?

3 MISS LAMONT: I think there are over  
4 100 students in McGill in the post-graduate level at  
5 the moment; they are not all from Quebec but quite a  
6 number are.

7 COMMISSIONER FIRESTONE: We are just  
8 trying to get some guidance from you, as the Chairman  
9 said earlier. Is it five or ten?

10 MISS LAMONT: Within the one institution  
11 I would think I could use 20, if that is any guide.

12 COMMISSIONER FIRESTONE: Therefore,  
13 for the Province of Quebec, if there was something like  
14 50, it would be, in your opinion, a reasonable beginning?

15 MISS LAMONT: Yes.

16 COMMISSIONER FIRESTONE: Thank you very  
17 much.

18 THE CHAIRMAN: Thank you very much,  
19 Miss Merleau and your associates. This has been a very  
20 helpful presentation and we are very much indebted to  
21 you for the time that you put into the preparation of  
22 the brief and in the assistance that you have been to  
23 us here this afternoon. Thank you again.

24

25

26

27

28

29

30



COMMISSIONER FLEMING: I could you

start off with five or ten or fifty?

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100 students in McGill in the post-graduate level and

the majority; they are not all from Quebec, but quite a

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much.

THE CHAIRMAN: Thank you very much.

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valuable presentation and we are very much indebted to

you for the time that you put into the preparation of

the paper and in the assistance that you have been to

us here this afternoon. Thank you again.



SUBMISSION OF THE PROVINCE OF QUEBEC

PHYSIOTHERAPISTS INCORPORATED.

Appearances: Miss Gwen Gower-Rees  
Mrs. Francoise Goulet  
Miss Edith Aston

THE CHAIRMAN: The submission of the  
Quebec Physiotherapists Incorporated will be Exhibit  
No. 220.

--- EXHIBIT NO. 220: Submission of the Province of  
Quebec Physiotherapists Incorporated.

MISS GOWER-REES: Miss Aston is on my  
left and Madame Goulet on my right.

THE CHAIRMAN: Would you proceed please?

MISS GOWER-REES: Before we start, I  
would like to just read pages 5 and 6 of our submitted  
brief. Previous to this we have discussed our needs  
and we end up on page 5 with suggestions for meeting  
these things.

SUGGESTIONS FOR MEETING THESE NEEDS

1. Training facilities for physio-  
therapists must be implemented by:

a. Urging the formation of schools in  
other Universities with Faculties of  
Medicine.

b. Enlarging the existing schools.

c. Training more teachers of physio-  
therapy.

2. The increase of student candidates

by:



Apparatus: Miss Gwen Gower-Ross  
Miss Edith Aston

THE CHAIRMAN: The submission of the

Quebec Physiotherapists Incorporated will be Exhibit

EXHIBIT NO. 190: Submission of the Province of  
Quebec Physiotherapists Incorporated

MISS GOWER-ROSS: Miss Aston is on my

left and Madame Goulet on my right.

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a. Urging the formation of schools in

other Universities with faculties of

medicine.

b. Enlarging the existing schools.

c. Training more teachers of physio-

therapy.

d. The increase of student candidates



- 1 a. Offering more financial assistance
- 2 through provincial aid.
- 3 b. Increasing public awareness of
- 4 the profession, particularly directed
- 5 to the student who is considering a
- 6 career.
- 7 3. The incentive to remain in the
- 8 profession must be augmented by:
- 9 a. The offer of bursaries or grants
- 10 for the training of teachers of physio-
- 11 therapy, for specialized professional
- 12 courses and for postgraduate research.
- 13 b. The recognition of a salary scale
- 14 which complements years of training,
- 15 experience and the increase of responsi-
- 16 bility.
- 17 4. The improvement of departmental
- 18 organization by:
- 19 a. The more widespread use of clerical
- 20 and housekeeping assistance to relieve
- 21 the physiotherapist of non-professional
- 22 duties.

### 23 CONCLUSION

24 Facilities for physiotherapy should be  
25 extended to all hospital institutions and centres provi-  
26 ding care for the acute and the chronically ill:

- 27 a. By increasing the medical and public
- 28 awareness of the value of physiotherapy.
- 29 b. By extending the present health
- 30 services.



a. offering more financial assistance

through hospital etc.

b. increasing public awareness of

the importance of mental health

to the student who is considering a

3. The incentive to remain in the

profession must be augmented by:

a. The offer of bursaries or grants

for the training of teachers of physical

education and for postgraduate research

courses and for postgraduate research

b. The recognition of a salary scale

which complements years of training

experience and the increase of responsibility

4. The improvement of departmental

organization by:

a. The more widespread use of clinical

and laboratory assistance to relieve

the physical therapist of non-physical

services

### CONCLUSION

Facilities for physiotherapy should be

extended to all hospital institutions and centres providing

care for the acute and the chronically ill:

a. By increasing the medical and public

awareness of the value of physiotherapy

b. By extending the present health

services





- 1 c. By expanding rehabilitation and  
2 convalescent programmes.  
3 d. By ensuring an adequate number of  
4 physiotherapist to staff these centres.

5 This outline is presented with the  
6 knowledge that some of the problems must remain with  
7 the Province of Quebec Physiotherapists Incorporated and  
8 the two Universities, but it is also evident that  
9 government assistance for training physiotherapists and  
10 increasing treatment facilities is essential.

11 THE CHAIRMAN: Thank you, Miss Gower-  
12 Rees.

13 COMMISSIONER VAN WART: You speak of  
14 government assistance. That is the local government,  
15 the Provincial?

16 MISS GOWER-REES: The Provincial  
17 Government.

18 COMMISSIONER BALTZAN: What attracts  
19 candidates to your work at the present time?

20 MISS GOWER-REES: At the present time  
21 it is rather a difficult question to answer, but we  
22 have previously been to the high schools and spoken to  
23 students. We get students to come around our hospitals  
24 to see what physiotherapy is, and I think the attraction  
25 of physiotherapy is that it is an active, I say,  
26 interesting, which is hard to define; it is an active  
27 profession within a hospital but it is not being a nurse.  
28 It is not being an occupational therapist or a dietitian  
29 or a social service worker.

30 We feel that part of the attraction is

3. By expanding rehabilitation and

4. By ensuring an adequate number of

physiotherapists to staff these centres.

This outline is presented with the

knowledge that some of the problems must remain with

the Province of Quebec Physiotherapists Incorporated and

the two Universities, but it is also evident that

government assistance for training physiotherapists and

increasing treatment facilities is essential.

THE CHAIRMAN: Thank you, Miss Goss-

COMMISSIONER VAN WAT: You speak of

government assistance. That is the local government,

Government.

COMMISSIONER BARTON: What subjects

relates to your work at the present time?

MISS GOWEN-WOOD: At the present time

it is rather a difficult question to answer, but we

have previously been to the high schools and spoken to

students. We got students to come around our hospitals

to see what physiotherapy is, and I think the attraction

of physiotherapy is that it is an active, I say,

interesting, which is hard to define; it is an active

profession within a hospital and it is not being a nurse.

It is not being an occupational therapist or a dietitian

or a social service worker.

We feel that part of the attraction is



1 due to the contact with the patient.

2 COMMISSIONER BALTZAN: What are the  
3 requirements to enter one of these schools?

4 MISS ASTON: The requirements to enter  
5 McGill University are, after attaining matriculation  
6 level, is 70% and satisfactory writing of the scholar-  
7 ship boards which has just been instituted at McGill  
8 University.

9 This year it is the same basic standard  
10 as that set for entrance into the Faculty of Science at  
11 McGill.

12 COMMISSIONER BALTZAN: What is the  
13 length of the course?

14 MISS ASTON: There is a three-year  
15 diploma course and a five-year degree course.

16 COMMISSIONER FIRESTONE: Mr. Chairman,  
17 the suggestion has been made that there is a shortage  
18 of 80 therapists in the Province of Quebec, and under  
19 Section 5, on page 5, you make a number of suggestions  
20 of how young people could be persuaded to take up this  
21 profession.

22 One of the suggestions you make under  
23 paragraph 2a is to offer more financial assistance.  
24 Could you explain to us specifically what kind of  
25 financial assistance you have in mind?

26 MRS. GOULET: Well, so far, we have  
27 some assistance from the Ministere de la Jeunesse, which  
28 supplies a number of bursaries, but we would like it to  
29 be more, if possible.

30 COMMISSIONER FIRESTONE: How much are





one to the contact with the patient.

COMMISSIONER BALTZAN: What are the

requirements to enter one of these schools?

MISS ASTON: The requirements to enter

University of Toronto are as follows:

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ship boards which has just been instituted at McGill

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This year it is the same basic standard

as that set for entrance into the Faculty of Science at

COMMISSIONER BALTZAN: What is the

length of the course?

MISS ASTON: The course is five years.

diploma course and a five-year degree course.

the suggestion has been made that there is a shortage

of 80 students in the Province of Quebec, and under

Section 5, on page 5, you make a number of suggestions

of how young people could be persuaded to take up this

profession.

One of the suggestions you make under

paragraph 2a is to offer more financial assistance.

Could you explain to us specifically what kind of

financial assistance you have in mind?

MRS. GOWDER: Well, so far, we have

some assistance from the Ministry of Education, which

supplies a number of scholarships, but we would like it to

be more, if possible.

COMMISSIONER BALTZAN: How much are



1 those bursaries?

2 MRS. GOULET: At the University of  
3 Montreal at the moment in the first year we have six  
4 of these bursaries; they go from \$200 to \$500. There  
5 are some at 300 and 400, but they range there, 200 to  
6 500 seems to be the highest.

7 COMMISSIONER FIRESTONE: Are these  
8 amounts adequate enough to attract a large enough  
9 number of young people into this profession? Are the  
10 amounts adequate enough in your opinion?

11 MRS. GOULET: Well, it is adequate for  
12 the ones that live in the city but it is not adequate  
13 for the ones that come from other towns or that have to  
14 pay for their living expenses.

15 COMMISSIONER FIRESTONE: Would you like  
16 to attract a number of young people from the rural  
17 areas to take this course, so that they might go back?

18 MRS. GOULET: Yes, definitely. We try  
19 to attract them.

20 COMMISSIONER GIRARD: May I make the  
21 comment while you are talking about these bursaries  
22 that 40% of this amount has to be repaid.

23 MRS. GOULET: I thought it was simply  
24 a loan that had to be refunded.

25 COMMISSIONER GIRARD: 40% has to be  
26 repaid, the rest is bursary.

27 COMMISSIONER FIRESTONE: Would you  
28 therefore suggest that in order to attract such young  
29 people from the rural areas that a larger amount would  
30 be indicated? What amount would you consider appropriate?



These figures?

MRS. GOWLEY: At the University of

Montreal at the moment in the first year we have six  
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a loan and had to be repaid.

Commissioner Gurnea: 50% has to be

repaid, the rest is bounty.

rather than suggest that in order to attract such young  
people from the rural areas that a larger amount would  
be indicated? What amount would you consider appropriate?





1 MRS. GOULET: I certainly would suggest,  
2 at least I think when we talk about graduates we say  
3 \$2,000 a year.

4 COMMISSIONER FIRESTONE: For under-  
5 graduates?

6 MRS. GOULET: Well, that is a lot for  
7 undergraduates, but it would cost them that.

8 MISS ASTON: It costs the undergraduate  
9 to train, who does not live in the city, \$2,000 a year,  
10 including her living expenses, books and uniforms.

11 COMMISSIONER FIRESTONE: Would your  
12 recommendation be that the scholarships be a full amount  
13 or a partial amount, like a thousand dollars? What  
14 would be your judgment?

15 MRS. GOULET: For undergraduates we  
16 would say a partial amount, because they might not get  
17 to graduation.

18 COMMISSIONER FIRESTONE: What would you  
19 consider a partial amount, a thousand dollars?

20 MRS. GOULET: Yes, a thousand dollars.

21 COMMISSIONER FIRESTONE: And for  
22 graduates what would you consider appropriate?

23 MRS. GOULET: Two thousand.

24 COMMISSIONER FIRESTONE: Would you feel  
25 that these scholarships should be made available to the  
26 students to the full extent, without the necessity of  
27 having to repay 40% as is presently the case?

28 MRS. GOULET: This is hard to answer.  
29 Well, I would say that if we ask help, I think it should  
30 not be repaid. I think it should be as bursaries. I



1 Mrs. GILBERT: I certainly would answer.

2 at least I think when we talk about graduates we say

3 \$2,000 a year.

4 COMMISSIONER FIRSTONE: Now under

5 graduation

6 Mrs. GILBERT: Well, that is a lot for

7 university students, but it would cost less than that.

8 The State has been and live in the city \$2,000 a year,

9 including not living expenses, books and uniforms.

10 COMMISSIONER FIRSTONE: Is that the scholarship for a full amount

11 or a partial amount, like a thousand dollars? What

12 would be your assignment?

13 We would say a partial amount, because they might not get

14 to graduation.

15 COMMISSIONER FIRSTONE: What would you

16 consider a partial amount, a thousand dollars?

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20 that these scholarships should be made available to the

21 students to the full extent without the necessity of

22 having to repay 40% as is presently the case?

23 Mrs. GILBERT: This is hard to answer.

24 Well, I would say that if we ask help, I think it should

25 not be repaid, I think it should be as permanent.



1 don't know if Miss Gower-Rees feels the same way.

2 MISS GOWER-REES: I would like to add  
3 a remark. I don't wish to disagree with Madame Goulet  
4 but I think that if a certain amount has to be repaid  
5 we might be in a position whereby we could keep the  
6 girls in the province which is what we really need and  
7 if they have an obligation to the province they have  
8 got to stay for a certain length of time and repay.

9 THE CHAIRMAN: Or?

10 MISS GOWER-REES: Or, yes.

11 COMMISSIONER FIRESTONE: Can you finish  
12 the or?

13 THE CHAIRMAN: No, I mean is that what  
14 you would like, the conditional bursary?

15 MISS GOWER-REES: Speaking provincially,  
16 yes.

17 COMMISSIONER FIRESTONE: I was just  
18 wondering whether the or meant that if these students  
19 were to remain in the Province of Quebec, say, for three  
20 years, that the 40% which they would otherwise have to  
21 repay would be remitted; in other words, it would be  
22 a tied scholarship designed to persuade them to stay  
23 and if they didn't stay they would repay the 40%?

24 MISS GOWER-REES: That is what I had  
25 in mind.

26 COMMISSIONER FIRESTONE: How many such  
27 bursaries, or scholarships are given at the present time,  
28 of the much more reduced amounts that you have been  
29 mentioning, in the Province of Quebec?

30 MISS ASTON: There are about 25 bursaries





don't know if Miss Gower-Hess feels the same way.

MISS GOWER-HESS: I would like to say

a word. I don't wish to disagree with Miss Gower

but I think that if a certain amount has to be repaid

we must be in a position whereby we could keep the

girls in the province which is what we really need and

if they have an obligation to the province they have

got to stay for a certain length of time and repay.

COMMISSIONER FLETCHER: Can you finish

the way

THE CHAIRMAN: No, I mean is that what

you would like, the conditional repayment?

yes.

COMMISSIONER FLETCHER: I was just

wondering whether the amount that if these students

were to remain in the Province of Quebec, say, for three

years, that the boys which they would otherwise have to

repay would be repaid; in other words, it would be

a kind of scholarship assigned to reimburse them to stay

and if they didn't stay they would repay the boys?

MISS GOWER-HESS: That is what I was

saying.

THE CHAIRMAN: How many would

be affected, or scholarships are given on the present time,

or the cash more is paid and then you have to

repay them, in the Province of Quebec?

MR. ALLEN: There are about 25 families



1 available at the moment.

2 COMMISSIONER FIRESTONE: And you feel  
3 that this number is not adequate?

4 MISS ASTON: With the schools this is  
5 adequate to supply the needs of the student but if  
6 these schools are developed then we will need more  
7 bursaries.

8 COMMISSIONER FIRESTONE: And you are  
9 recommending that new facilities be made available so  
10 that you can catch up with that shortage that exists; is  
11 that right?

12 MISS ASTON: Yes.

13 COMMISSIONER FIRESTONE: If that objec-  
14 tive of yours is realized, how many scholarships a year  
15 do you feel that you would require?

16 MISS ASTON: If we have 25 now and we  
17 hope to enlarge our existing facilities and set up new  
18 schools, another 25 would be required.

19 COMMISSIONER GIRARD: Do you feel that  
20 you are limited to a certain amount of these bursaries  
21 because these bursaries, if I am not mistaken, are not  
22 exclusively physiotherapists' bursaries; they are youth  
23 training grants that are given by the Provincial Govern-  
24 ment to any university students.

25 They are even given to students in  
26 schools of nursing. The amount is smaller and everyone  
27 is tied up to this same thing, they have to reimburse  
28 40%. So is there a ceiling on the number of bursaries  
29 of this kind of bursary that you can get?

30 MRS. GOULET: If you are talking about



1 available at the moment.

2 COMMISSIONER FINSTON: And you feel

3 that this number is not adequate?

4 MISS ASTON: With the schools this is

5 adequate to supply the needs of the student but if

6 these schools are developed then we will need more

7 COMMISSIONER FINSTON: And you are

8 recommending that new facilities be made available so

9 that you can catch up with what elsewhere that exists; is

10 that of yours is received, how many scholarships a year

11 do you feel that you would receive?

12 MISS ASTON: If we have 25 now and we

13 hope to enlarge our existing facilities and set up new

14 schools, another 25 would be required.

15 COMMISSIONER FINSTON: Do you feel that

16 you are limited to a certain amount of these practices

17 because these practices, if I am not mistaken, are not

18 exclusively in the hands of the business; they are youth

19 training centers that are given by the Provincial Govern-

20 ment to any university students.

21 They are given to students in

22 schools of nursing. The amount is smaller and everyone

23 is tied up to this same thing, they have to reimburse

24 the Government a ceiling on the number of businesses

25 of this kind of business that you can get?

26 MISS ASTON: If you are talking about





1 the bursary from the Ministere de la Jeunesse,, I don't  
2 think we should have.

3 COMMISSIONER GIRARD: There is no limit  
4 to that, no, you can have as many as you apply for if  
5 the student comes within the limits or the income of her  
6 family is within a certain limit.

7 MRS. GOULET: But I think Miss Aston  
8 was referring to bursaries that would pay the full  
9 amount without any remittance.

10 COMMISSIONER BALTZAN: Is the great  
11 impediment an economic one or is it one of position or  
12 status that is interfering with an adequate number of  
13 candidates or applicants to enter into this profession?

2 14 MISS GOWER-REES: I think at the  
15 moment it is an economic one, by virtue of the fact  
16 that once these girls have entered university, gone  
17 through three or five years of training and spent a  
18 considerable sum of money, the salaries offered when  
19 they get out into the field are not adequate in many  
20 cases. They vary in many institutions.

21 THE CHAIRMAN: How do those salaries  
22 compare with the salaries of the registered nurse at  
23 graduation?

24 MISS GOWER-REES: They are a little  
25 bit higher than the registered nurse and I am afraid I  
26 cannot quote the figures.

27 COMMISSIONER BALTZAN: And with the  
28 schoolteacher?

29 MISS GOWER-REES: Now a little bit  
30 lower.





1 COMMISSIONER VAN WART: Is the 70%  
2 requirement for entrance a hindrance at all for getting  
3 candidates?

4 MISS ASTON: I don't feel that it is a  
5 hindrance because before we had this 70% requirement  
6 we were failing out 20 to 30% at the first year. So  
7 this means that the candidates we do get at this level  
8 will be able to remain with us and cope with the course.

9 MRS. GOULET: So far, at the University  
10 of Montreal, we have not imposed the 70% but I think  
11 we will have to because we find we are having to fail  
12 a great percentage of the first year.

13 COMMISSIONER VAN WART: But these girls  
14 who apply evidently want to be physiotherapists but  
15 they haven't got the qualifications academically to  
16 become physiotherapists.

17 MRS. GOULET: Yes.

18 COMMISSIONER McCUTCHEON: Dr. Baltzan  
19 asked if the economic factor was an inhibiting factor,  
20 Miss Gower-Rees, and you said it was but then in your  
21 explanation you indicated that it was the economic  
22 factor that applied after graduation. To what extent  
23 do you consider that the economic factor is a barrier  
24 to the student entering?

25 Let us suppose the salaries were ten  
26 thousand a year on graduation. Are there many students  
27 you find that cannot afford to go to the school, cannot  
28 afford the fees and board and lodging, say, and so on?

29 MISS ASTON: As yet we have never been  
30 able to stop a student going through if she really





COMMISSIONER VAN WART: Is the 70%

requirement for entrance a hindrance at all for getting

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COMMISSIONER VAN WART: But these girls

who apply evidently want to be physiotherapists but

they haven't got the qualifications academically to

become physiotherapists.

MRS. GORDON: Yes.

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then you're dead and you said it was but then in your

explanation you indicated that it was the economic

factor that applied at the graduation. To what extent

do you consider that the economic factor is a barrier

to the student entering?

But we suppose the salaries were ten

thousand a year in graduation. And there many students

you find that cannot afford to go to the school, cannot

afford the fees and board and lodging, say, and so on?

MRS. GORDON: As yet we have never been

able to stop a student going through it and really



1 wanted to become a physiotherapist. We have always  
2 found someone who would supply the money. There has  
3 always been a source.

4 COMMISSIONER McCUTCHEON: Thank you  
5 very much. It was suggested to us when the occupational  
6 therapists were making their presentation this morning  
7 that the mere opening of another school in another  
8 district, for example, a school in connection with the  
9 Faculty of Medicine at Laval, would automatically  
10 attract a group of girls who would, under no circumstances,  
11 come to either McGill or to the University of Montreal  
12 and I think the evidence was that out of some 260-odd  
13 girls at the University of Toronto in occupational and  
14 physiotherapy, some 80% came from within the radius of  
15 100 miles.

16 Would you agree with that conclusion?

17 MISS GOWER-REES: We would.

18 COMMISSIONER McCUTCHEON: Then one of  
19 the quickest ways of adding to your supply might be to  
20 make this profession available in Quebec City to girls  
21 in that part of the province who otherwise discard that  
22 profession for something else they can obtain more  
23 close to home?

24 MISS GOWER-REES: Yes.

25 COMMISSIONER McCUTCHEON: Is this  
26 reference to a shortage of 80 physiotherapists, as I  
27 read your brief, that shortage is related only to the  
28 29 institutions which employ any physiotherapists?

29 MISS GOWER-REES: That is so, yes.

30 COMMISSIONER McCUTCHEON: Then do you



...to become a physiotherapist. We have always  
found someone who would supply the money. There has  
always been a source.

very much. It was suggested to us when the occupational  
therapists were making their presentation this morning  
that the more opening at another school in another  
district, for example, a school in connection with the  
Faculty of Medicine at Laval, would automatically  
attract a group of girls who would, under no circumstances  
come to either McGill or to the University of Montreal  
and I believe the evidence was that out of some 200-odd  
girls at the University of Toronto in occupational and  
physiotherapy, some 80% come from within the radius of  
100 miles.

Would you agree with that conclusion?  
MISS JONES-REID: We would.

COMMISSIONER McLEOD: Then one of  
the greatest ways of solving the problem would be to  
make this profession available in Quebec City to girls  
to that part of the province who otherwise stand that  
prospect for something else they can obtain more  
easily in money?

COMMISSIONER McLEOD: In this  
reference to a shortage of physiotherapists, as I  
read your paper, that shortage is related only to the  
20 institutions which employ any physiotherapists?  
MISS JONES-REID: That is so, yes.  
COMMISSIONER McLEOD: Then do you





1 agree that that is the shortage or is the shortage very  
2 much greater? If only 29 out of 259 hospitals have any  
3 physiotherapists I would be forced to conclude that the  
4 shortage is considerably greater than you indicate.'

B/dpw

5 MISS GOWER-REES: It is considerably  
6 greater, sir. I worked it out this morning and if the  
7 259 hospital institutions which we understand exist  
8 in the Province were manned according to the manning  
9 standards of 1.5 therapists per 100 beds we would need  
10 18,000 therapists.

11 COMMISSIONER McCUTCHEON: I doubt very  
12 much if you are going to get them. Thank you very much.

13 COMMISSIONER BALTZAN: You limit the  
14 conversation here to girls applying. What about men?

15 MISS GOWER-REES: Men can apply. Men  
16 can be considered for application both in the University  
17 of Montreal and, not in McGill, but in the Toronto  
18 University. We have men studying in both universities.

19 THE CHAIRMAN: Why not?

20 MISS ASTON: At the present time we  
21 don't have the facilities. We are considering it.

22 THE CHAIRMAN: I imagine the girls  
23 would love it.

24 MISS ASTON: I imagine they would.

25 THE CHAIRMAN: Thank you very much,  
26 ladies, for your attendance here this afternoon. As  
27 you will appreciate the submission from an Association  
28 such as yours rounds out the information that we have  
29 from other organizations and eventually it will be of  
30 great help to us in seeing the picture of the situation





1 as a whole.

2 We thank you very much.

3 MISS GOWER-REES: Thank you very much.

4 THE CHAIRMAN: We will rise until

5 9.30 tomorrow morning.

6

7 --- Adjournment.

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MISS GOWDER-BRENN: Thank you very much.

THE CHAIRMAN: We will pass until

9:10 for a short while.

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# ROYAL COMMISSION ON HEALTH SERVICES

ENGLISH VERSION

HEARINGS

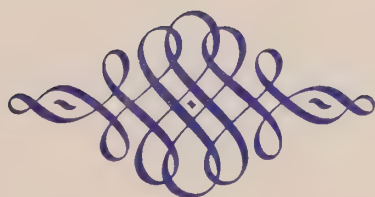
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E R R A T A

Suggested Necessary Corrections to Transcript of the Royal Commission Hearings of March 22, 1962, Volume 36, Pages 7359 - 7453, as prepared by Angus, Stonehouse & Co. Limited.

<u>Page</u>	<u>Line</u>	<u>Correction</u>
7367	28	Insert a comma after "wants" and after "wishes"
7368	19	Change "disadvantages" to "advantages"
7368	24	This line should be changed to read "learned, moncpsony - a monopoly is where there is one"
7368	25	Change "monocracy" to "monopsony"
7370	4	Change "company copies it." to "companies copy it."
7371	4	Change "the same" to "a different"
7373	2	After "danger" add "that many would leave." and "people" to "People"
7373	5	Change this line to read "the street or stay where they are is important. Almost certainly many"
7373	6	Insert "would" after "men".
7373	7	Insert after "hesitate" "to say that this" (delete the --)
7374	9	Change this line to read "question that the growth of life insurance and"
7374	13	After "employees" delete the ; and add "or"
7374	21	Insert "these" before "acquisition"
7374	22	This line should be changed to read "costs. You are just told pay your money, pay"
7376	11	Change "of" to "and"
7377	25	Change "KILGOUR" to FITZHUGH"
7378	16	Add "or" after "four"
7378	23	Change "quote" to "collect"
7378	27	Change "a form" to "the figures"
7379	4	Insert a period after company. Change "under" to "Under"
7379	5	Change "or" to "are"







Page 2 of Necessary Corrections

<u>Page</u>	<u>Line</u>	<u>Correction</u>
7379	10	Insert "it" before "goes"
7379	17	Delete comma after "deductions" and insert "for"
7379	21	Insert "It" before "Covered" and change "Covered" to "covered"
7380	8	Insert "They" before "Paid" and change "Paid" to "paid"
7381	5	This line should be changed to read "anything, except pay a bill, as for their telephone".
7381	13	Change this line to read "From this experience to quote a phrase, a government plan,"
7381	25	Change "send" to "pay"
7381	26	Insert after "pay" "the same way."
7385	22	Insert "the" before "casualty"
7385	23	Change "contracts out" to "coverage as"
7386	12	Change to read "If you have only poor risks you end up"
7386	25	The last word in this line should be "young"
7388	23	Change this line to read "companies and prepaid plans as a whole, can bring it"
7389	28	Change "no more" to "less"
7390	4	Insert after "underwriting" "later"
7390	14	Change "FITZHUGH" to "KILGOUR"
7390	19	This line should be changed to read: "in the provisions. I think there is pretty general"
7390	20	Change "severity" to "uniformity"
7390	26	Change "FITZHUGH" to "KILGOUR"
7390	29	Change "superintendent" to "superintendents"
7394	15	Change this line to read "MR. KILGOUR: It varies widely between employers."
7394	16	Change "in" to "In"
7396	16	Change "50-cent" to "50 percent"
7396	29 and 30	Change these lines to read "There may be an element of compulsion as a member of this community but"





Page 3 of Necessary Corrections

<u>Page</u>	<u>Line</u>	<u>Correction</u>
7397	11	The last word should be "condition"
7397	12	The first word should be "of"
1399	17	Insert "expense" before "rate"
7399	19	Add at the end of the line "other"
7399	25	Insert "dividend" before "return"
4701	2	Change "collecting treatment" to "collection machinery"
7401	3	Change "classify the" to "apply to"
7403	23	Insert "waiting" before "period"
7404	6	Insert "the loss" before "will"
7404	12	Change the second "they" to "we"
7405	1	Insert "for" after "that"
7405	12	Change "like" to "unlike"
7405	25	Change "costs" to "cases"
7405	27	Delete "on"
7405	29	Change "any" to "a company's"
7406	11	Change "a" to "the"
7406	12	Insert a comma after "it"
7408	23	Change "annual" to "original"
7411	13	Insert "perhaps" after "handling"
7411	14	Change "of" to "for"
7411	20	This line should be changed to read "a particular name but they can just as easily have"
7411	22	Insert "and dependants" after "employees"
7412	5	Insert "would" before "say"
7412	7	Change "bretherns" to "brethren"
7412	30	Change this line to read "a surgical schedule. Frequently for example, if"
7413	24	Change "plan is" to "plans are"
7413	25	Change "plan" to "plans"
7413	26	Delete the comma after "scheduled". Insert "it" before depends"







Page 4 of Necessary Corrections

<u>Page</u>	<u>Line</u>	<u>Corrections</u>
7415	10	Change "nurses" to "surgeons"
7415	17	Change "we" to "and"
7415	18	Change this line to read "pay a percentage of the schedule, or it says we"
7419	16	Change "read" to "ready"
4723	15	Delete "a"
7428	11	Change "wholly" to "almost"
7432	27	Change this line to read "bills you can think of and that covers the health costs of 73% of our employee"
7437	4	Delete the word "and"
7437	5	Delete the entire line
7437	6	Delete "cular year"
7439	2	Insert "for" before "Those"
7441	2	Change "this" to "a"
7441	13	Change "employable-employer" to "employee-employer"
7441	14	Change "may" to "many"
7444	22	Insert "in" before "the"
7449	10	Change "not" to "now"
7449	11	This line should be changed to read "expressions of desire in signing up for a plan for health insurance are reflected,"
7452	1	Change "and" to "at".







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## E R R A T A

Optional Corrections to transcript of the Royal Commission hearings of March 22, 1962, Volume 36, Pages 7359-7453, as prepared by Angus, Stonehouse & Co. Limited.

Marginal  
Number

Page

Line

- |    |      |    |   |
|----|------|----|---|
| 1  | 7369 | 10 | Before "new" insert "and been an inducement for" and change "coming" to "to come"           |
| 2  | 7369 | 11 | Delete "It is important" and insert "It might be admitted"                                  |
| 3  | 7369 | 18 | Delete "some"   |
| 4  | 7369 | 26 | Delete "in as it is" and insert "the same as"   |
| 5  | 7372 | 18 | Delete "in" and insert "with"   |
| 6  | 7372 | 19 | Change "indicate" to "indicates"  |
| 7  | 7372 | 21 | Change "anywhere" to "everywhere"   |
| 8  | 7372 | 29 | Change "Canadians" to "Canadian"  |
| 9  | 7372 | 30 | Delete "but"  |
| 10 | 7375 | 15 | After "preserve" insert "the standard of"   |
| 11 | 7375 | 18 | Change "advantages" to "advantage" and change "has" to "is"                                 |
| 12 | 7375 | 19 | Put period after "choice", delete "which the" and change "experience" to "Experience"       |
| 13 | 7375 | 23 | Change "on" to "about"  |
| 14 | 7375 | 26 | Change "him" to "them" and change "On the prepayment policy plan" to "The prepayment plans" |
| 15 | 7376 | 6  | Change "in" to "on"   |
| 16 | 7376 | 30 | Delete "on"   |
| 17 | 7377 | 1  | Change "is paid to the agent" to read "paid to the agent is"                                |
| 18 | 7377 | 9  | Change "that costs" to "the costs"  |
| 19 | 7378 | 18 | Change "techniques" to "technique" and change "has" to "have"                               |
| 20 | 7379 | 6  | Delete comma after "physicians" and insert apostrophe                                       |
| 21 | 7379 | 18 | Insert comma after "year"   |





Page 2 of Optional Corrections

<u>Marginal Number</u>	<u>Page</u>	<u>Line</u>	
22	7386	23	Change "into" to "in to"
23	7389	14	Change "it" to "we"
24	7390	10	Change "principal" to "principle"
25	7397	12	Insert "for" after "say"
26	7397	13	Change "policy" to "employment"
27	7397	14	Change "suggest" to "suppose"
28	7397	17	Delete "not"
29	7397	30	Change "your" to "their"
30	7398	5	Put a period after "Plan" and change "for" to "For"
31	7398	11	Change "the" to "a"
32	7399	12	Change "or" to "so" and "and" to "for"
33	7400	7	Change this line to read "because you have to collect an individual premium instead of a bulk premium. It costs"
34	7402	11	Delete "if"
35	7402	12	Put a period after "line" and change "it" to "It"
36	7407	8	Change "issued" to "issuing"
37	7407	9	Change "in" to "for"
38	7407	30	Delete "was"
39	7409	15	Delete last word "they"
		16	Delete first word "claim"
40	7413	20	Change "however" to "However"
41	7418	23	Change "medical situation" to "hospital insurance legislation"
42	7419	3	Change "policy" to "premium"
43	7422	11	Change "life" to "health"
44	7424	2	Change "somewhat outside the possibility" to "somewhat an outside possibility"
45	7425	14	Insert a period after the last word "responsibility" on line 13 and delete entire line 14.







Page 3 of Optional Corrections

Marginal  
Number

Page Line

46 7427 30 Delete "and"

47 7429 28 Insert "different" before  
"foundation"

48 7433 11 Delete "but"

49 7435 5 Insert "heavy" before "health"

50 7435 12 to 16 Change lines 12 to 16 to read  
"I think that is one of the  
critical advantages of a voluntary  
health insurance scheme. I do  
not think I or Mr. Kilgour or  
Mr. Berry or anybody else can  
say what is heavy for Mr. John  
Doe. The only fellow who can  
decide that is Mr. John Doe."







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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearing held  
at Montreal, Friday, April  
13th, 1962.

COMMISSION MEMBERS:

Chief Justice EMMETT M. HALL -- Chairman

Miss ALICE GIRARD, R.N.

Dr. DAVID M. BALTZAN

Prof. O.J. FIRESTONE

Mr. M. WALLACE McCUTCHEON, Q.C.

Dr. C. L. STRACHAN

Dr. ARTHUR F. VAN WART

COMMISSION COUNSEL:

Mr. R.N. HALL, Q.C.

MEDICAL CONSULTANT:

Dr. PIERRE JOBIN

DIRECTOR OF RESEARCH:

Prof. BERNARD BLISHEN

SECRETARY:

Mr. N. LAFRANCE





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TORONTO, ONTARIO

8337

Montreal, Province of  
Quebec,  
April 13, 1962.

---On commencing at 9:30 a.m.

THE CHAIRMAN: We will come to order  
and proceed with the submission of Societe des Infirmieres  
Visiteuses.

THE SECRETARY: Mr. Guertin will submit  
the brief to the Commission and read the recommendation.

SUBMISSION OF  
SOCIETE DES INFIRMIERES VISITEUSES

APPEARANCES:  
Miss M.P. Hamel  
Miss R. Rivard  
Mr. P. Guertin  
Mrs. G. Jacobs  
Mr. J.E. Boucher  
Dr. H. Trudel

MR. GUERTIN: I should like to introduce  
my colleagues, the directoress of the Societe des  
Infirmieres Visiteuses, Miss Rivard, and Mr. Boucher  
who is general administrator; Mrs. Jacobs, directoress  
of teaching and Miss Hamel, director of administration.

Ladies and gentlemen, before beginning  
to read the recommendations and arguments in this brief  
I should like to bring to your attention additional  
documents which we have submitted this morning. The  
first sheets include the corrections to Appendix K.  
It is not a graph of visits, but a graph of increases.

THE CHAIRMAN: This is exhibit number 221  
and the appendix will be 221A.

MR. GUERTIN: Pages 15 in paragraph 13  
of our brief, sir, you will see the costs of the visits  
to the home, individual hospital costs, between \$15.00  
and \$20.00 a day to the state, but we need the hospital,





THE CHAIRMAN: We will now go on to

and proceed with the submission of documents and information.  
Very please.

THE SECRETARY: Mr. Gault will submit  
the letter to the Commission and read the recommendation.

Miss M. B. Hamer  
Miss R. Rivard  
Mrs. G. Jacob  
Mr. H. Thibault

APPENDIX

MR. GURTTIN: I should like to introduce

my colleagues, the directors of the Society for  
Unimpaired Visionaries, Miss Rivard, and Mr. Jacob  
who is general administrator; Mrs. Jacob, director  
of training and Miss Hamer, director of administration.  
Ladies and gentlemen, before beginning

to read the recommendations and arguments in this order  
I should like to bring to your attention additional  
documents which we have submitted this morning. The  
first of these includes the corrections to Appendix A.

It is not a copy of a visit, but a graph of the same.

THE CHAIRMAN: This is exhibit number 10.

and the appendix will be 11A.

MR. GURTTIN: Pages 10 in paragraph 10

of our report, and you will see the costs of the visit  
to the home, individual medical costs, between 10 and 15  
and 20 a day to the state, but we need the hospital,



Guertin

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3 and we need full hospital and nurses for every four  
4 patients to cover this practice. This means the nurse  
5 makes an average number of seven visits per day. This  
6 type of work is necessary when the period of  
7 convalescence begins. The use by the city of private  
8 services already require qualified personnel and this  
9 is a guarantee for the application of treatment of  
10 patients at home. In 1961 37 patients have benefitted  
11 from hospital insurance.

12 This is the statement made by Mr.  
13 Lesage at the conference in 1962. The Provincial  
14 Government paid to the hospital the sum of \$142 million.  
15 This is \$117.00 per patient in hospital. The average  
16 hospitalization was ten days. If we could reduce this  
17 figure, this figure will go from ten to nine and the  
18 treasury can reduce its expenditures by one-tenth.  
19 This will allow the hospital 86 patients per year.  
20 Secondly the beds that will thus be freed, that will  
21 be made available will suffice for a certain time  
22 until it will be necessary to build new hospitals.  
23 According to the pilot project that has been undertaken  
24 by our Society it will be one-third less expensive to  
25 give care to patients at their homes.

26 Other considerations: It will be less  
27 costly for the public treasury to buy, in certain cases  
28 the necessary drugs if these drugs are unable to be  
29 procured by less fortunate patients. The supervision  
30 carried out by the nurse during her visits will also  
keep the patient in relation with the doctor who treats  
them and with the hospital concerned.







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3 Recommendations: An extension of  
4 services and prospects for the family will continue to  
5 play its role in the principal articles set forth.  
6 Obviously our Society maintains contact with the public  
7 and it makes its services public by the newspapers and  
8 medical periodicals. Our Society proposes a large plan  
9 of operation which will cover the entire province of  
10 Quebec and can be considered as an extension of the  
11 services given to hospital patients. Since the patient  
12 receives the necessary treatment then he will be able  
13 to return home sooner provided that the doctor can  
14 follow up the treatment. Exemption of Hospitals: If  
15 a disease does not require admission to the hospital,  
16 the patient can benefit from nurses services at home.  
17 Considering the fact that health is the responsibility  
18 of the provincial ministry we hope that our services  
19 will remain private services recognized by the provincial  
20 authorities. We would like to say that the experience  
21 can be very costly when it was acquired because it  
22 always implies a certain trial period. The visiting  
23 nurse service can maintain a team of nurses to visit  
24 patients in their homes. In order to serve the population  
25 better there would be a reduction in the cost of  
26 administration. There would be supervision of the  
27 personnel attached, and there would be more security  
28 in training personnel. Governments would save a very  
29 important sum by subsidizing plans such as organizations  
30 like our society, Societe des Infirmieres Visiteuses.  
Respectfully submitted. Thank you.

THE CHAIRMAN: Commissioner Girard.





Guertin

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4 COMMISSIONER GIRARD: Mr. Chairman,  
5 Mr. Guertin, I have a few question. I think I will  
6 begin by a question dealing more particularly with your  
7 recommendations. If I am not mistaken your recommendations  
8 cover the point that it will be less costly for the  
9 government with respect to hospitalization insurance  
10 to allow the patients to be treated at home and to  
11 allow visiting nurses to treat the patients. In English  
12 and often in French we call this home care. I see  
13 that you have already begun two pilot projects. Can  
14 you explain these projects to us very briefly because  
15 many of us are not fully familiar with these projects.  
16 Is it too soon to tell us about the results obtained  
17 or about the prospects for the future?

18 MR. GUERTIN: Well, first, Mr. Chairman,  
19 we are very happy to give you some advance information  
20 on the pilot project, on the first pilot project. The  
21 second project, it is very new, it began only three  
22 months ago. It would seem according to the experience  
23 acquired during these first few months, this is simply  
24 a matter of home care and eventually in the home care,  
25 as you mention, it would appear that the cost is one-  
26 third of the cost of hospitalizing a patient in hospital.  
27 That is determined in the American experiment made  
28 of this type. You are more familiar with the American  
29 experiment than I am, the experiments in Philadelphia,  
30 New York and Seattle. There the cost of care of the  
patient at home represents about one-third of the cost  
of the care for the patient in hospital. Does this  
answer your question?







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4 COMMISSIONER GIRARD: Well, for the  
5 time being, I believe in the U.S.A. the cost is much  
6 more than one-third, but there are certain economics  
7 affected in constructing new hospitals. If we consider  
8 home care requires much more than nursing, and of course,  
9 if it was simply limited to nursing visits the cost  
10 would be relatively modest, but I wanted to ask you  
11 whether you had in your pilot project a complete team  
12 required for home care? When I say "team", I have in  
13 mind the very important individual in any system of  
14 home care, it is called the family auxiliary or homemaker  
15 in English, housekeeper.

16 MR. GUERTIN: Well, this organization  
17 doesn't concern itself, our society-- I am simply  
18 speaking of the care given by our own nurses, and I know  
19 for a fact that the home care project which we have  
20 organized includes not only a doctor and a nurse and a  
21 directoress of home care, but it also includes a  
22 social worker who will maintain the liaison between the  
23 family and the social assistance family, assistance  
24 agencies which may be required by a family which needs  
25 the treatment.

26 COMMISSIONER GIRARD: Well, is this team  
27 working in your plan?

28 MR. GUERTIN: No, it is not up to us. I  
29 don't believe you can expect us, as competent as we may  
30 be, to begin home care projects. It is a matter  
that concerns the hospital authorities and doctors and  
it is outside our scope of activity which is confined  
to home care. We give our services for a lump sum,







Guertin

8342

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3 actually, we are in association with the medical  
4 profession, but our activities are limited."

5 COMMISSIONER GIRARD: Well, may we --  
6 your service, not at this time, but in the future may  
7 have some broader affiliations. There are certain  
8 associations that have their own home makers who work  
9 within the Association and who more or less supplement  
10 the home care team. As you say home care can be  
11 organized in three ways, they can be organized jointly  
12 with the hospital. It can be organized as is done in  
13 Toronto together with a health service, a municipal or  
14 provincial health service or they can be organized in  
15 collaboration with an association or society such as  
16 yours. For the time being this is done in your case,  
17 because there are three ways of organizing home care .

18 MR. GUERTIN: Yes, of course, but I  
19 believe you have understood that because of our other  
20 tasks we can't undertake such an organization because  
21 our other tasks are sufficiently heavy to prevent us  
22 from being pioneers in this area, our own work is  
23 sufficiently important and takes up all our time.

24 COMMISSIONER GIRARD: I put this question  
25 simply to clarify the type of work you are doing so  
26 we may know exactly what is being done, and so we can  
27 be fully familiar with the work you are undertaking.  
28 I simply put the question so we can have it clear what  
29 your society is doing in relation to these programmes  
30 and since, I think it is included in your recommendations  
in the brief, you have no objection to discussing these  
matters in detail. You don't have information to furnish





Guertin

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3 in connection with this plan?

4 MR. GUERTIN: No, the plan is so recent  
5 we haven't sufficient information.

6 COMMISSIONER GIRARD: Have you had many  
7 visits?

8 MR. GUERTIN: Yes, our visits are  
9 increasing. Do you have the number of visits?

10 MRS. JACOBS: Yes.

11 MR. GUERTIN: About 170.

12 COMMISSIONER GIRARD: This represents  
13 how many cases?

14 MR. GUERTIN: Oh, about 20, approximately  
15 20.

16 MISS RIVARD: The statistics were  
17 published only yesterday.

18 COMMISSIONER GIRARD: In the cases that  
19 you have treated up to now would these cases require  
20 only the services of visiting nurses?

21 MISS RIVARD: No, the cases we are taking  
22 presently require home nursing, and they also require  
23 family assistance. They require doctors additionally,  
24 and sometimes therapy, and this represents a great deal  
25 of rehabilitation work which is done by our nurses who  
26 are specialists in rehabilitation work.

27 COMMISSIONER GIRARD: Are these cases  
28 supervised by physiotherapists?

29 MISS RIVARD: Yes, there is one therapist  
30 who is a member of this home care team.

31 COMMISSIONER GIRARD: You have had 20  
32 cases up till now?







Guertin

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4 MISS RIVARD: Well, this covers this  
5 past month, that is the month of March. The project  
6 began the first of December. It is quite new. It is  
7 not fully developed.

8 COMMISSIONER GIRARD: When you say  
9 according to experience the cost is about one-third of  
10 hospitalization for the patient, does this one-third  
11 represent the cost, your cost, or does it represent the  
12 total cost of the pilot project? These are statistics  
13 in the pilot project you are giving?

14 MISS RIVARD: Yes, as one-third of the  
15 cost of hospitalization of the patient including the  
16 home care given by the whole team, that is nurses and  
17 doctor and therapist, the assistant and social worker  
18 and the family social worker, and also the babysitter.

19 COMMISSIONER GIRARD: In other words you  
20 have to deal with all the specialties and this cost is  
21 about one-third of the hospitalization cost?

22 MISS RIVARD: Well, we hope to be able  
23 to give you -- we can't give you exact figures now  
24 because these figures are doubled with each passing  
25 month.

26 COMMISSIONER GIRARD: We are greatly  
27 interested in the home care because there are many  
28 organizations working in Canada and everybody requires  
29 home care. However, before beginning these projects  
30 and programmes the team must be fully equipped in  
order to furnish the necessary type of care required  
otherwise the patient will not receive the care which  
corresponds to his needs, and then he will have to be







Guertin

8345

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4 hospitalized and that is why I put this question to you.  
5 Let us suppose that this plan for home care becomes  
6 more widespread. Suppose that these two pilot projects  
7 are successful and you want to generalize this plan,  
8 do you consider it possible for your association with  
9 the number of nurses at your disposal, would it be  
10 possible with government aid to give this care for  
11 patients outside of the hospital? Do you think you could  
12 continue?

13  
14 MISS RIVARD: Yes, I believe it is  
15 possible to meet additional needs because we have  
16 organized our services in such a way that each nurse  
17 has a prescribed plan of action. I think it is possible  
18 to broaden our service. However we must adopt a planning  
19 programme in order to give an additional training to  
20 nurses for these services.

21  
22 COMMISSIONER GIRARD: I believe that you  
23 have 44 nurses now, 44 nurses who serve the entire  
24 french population in Montreal. It is very small. I  
25 believe in 15 years' time you can surely have a service  
26 including 200 french nurses which will give you home  
27 care and this will not be excessive. Now there are 44  
28 nurses for the french population in Montreal, well, if  
29 there were many home care programmes that were organized  
30 out of your association do you think you could meet  
the need?

MISS RIVARD: Yes.

MR. GUERTIN: You must bear in mind the  
number of nurses in our society depends on the demands  
for home care, on the requests submitted for such care.





Guertin

8346

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4 Furthermore since the establishment of free hospital  
5 treatment I think it is -- it will be possible to discard  
6 certain patients from the hospital who don't require  
7 hospital treatment. Furthermore we feel it wise to have  
8 several of our nurses become more specialized,  
9 particularly with respect to rehabilitation, with respect  
10 to psychiatric services and with respect to hygiene.  
11 We have at the present time visiting nurses and here I  
12 am going into what is a little foreign to me but I do  
13 not think it would be difficult to treat a patient at  
14 home rather than treating him in the hospital. We must  
15 show greater initiative here. When a person is treating  
16 a patient at home a greater initiative is called for  
17 than is called for by the same nurse in hospital. I  
18 do not think there is any problem here because these  
19 home care projects come one by one and as these projects  
20 increase we can meet the demand because the care given  
21 is given by the entire team of nurses. A request for  
22 care comes from the hospital and then it is relayed to  
23 the various regions in which our service operates.  
24 Of course, there will have to be an increase in our  
25 personnel to correspond with the increase in our  
26 services.

27  
28 COMMISSIONER GIRARD: Of the 44 nurses,  
29 how many are qualified to give public hygiene instruction?

30 MISS RIVARD: Twelve are qualified  
for public health. We have trained three for rehabilita-  
tion work.

COMMISSIONER GIRARD: You mention  
specialization, when you mention specialization do  
you mean public health?







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3 MR. GUERTIN: Yes. For a certain number  
4 of years now several of our nurses are taking specialized  
5 training. I use the word "specialization", perhaps we  
6 should use another word. We recognize the importance  
7 of these post-graduate courses to increase competence  
8 of our nurses and we also recognize there must be  
9 increased salaries paid to these nurses to correspond  
10 with their advanced training, for instance, in public  
health or rehabilitation or other areas.

11 COMMISSIONER GIRARD: When you mention  
12 specialization I believe that you mean that nurses  
13 studying public health should receive public health  
14 training without considering it as a specialty, as a  
15 specialization. I would consider these nurses should  
16 specialize in rehabilitation. Is your goal to obtain  
17 qualified nurses, and when I say "qualified nurses"  
18 I mean nurses who are trained in public health, to have  
a greater number of such nurses?

19 MR. GUERTIN: You mention a nurse who  
20 is specializing in public health or are you speaking  
21 of someone who gives home care?

22 COMMISSIONER GIRARD: Let us consider  
23 a nurse who is trained in public health, whether or  
24 not she gives home care or hospital care, they are both  
considered.

25 MR. GUERTIN: Our purpose is to encourage  
26 such specialists. We even give facilities to our nurses  
27 in order to acquire such specialization.

28 COMMISSIONER GIRARD: In your brief you  
29 mention scholarships, what are these scholarships and  
30 how can they be obtained and what is the sum of these







Guertin

8348

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4 scholarships?

5 MR. GUERTIN: I cannot give you any  
6 details.

7 MISS RIVARD: These scholarships are  
8 offered by the Provincial Government in accordance with  
9 the Federal and Provincial agreements. These  
10 scholarships are given each year and they are for the  
11 purpose of sending nurses out to the schools of public  
12 health. This is in addition to other courses which  
13 we have offered to our nurses such as science and  
14 rehabilitation work.

15 COMMISSIONER GIRARD: Excuse me, do you  
16 have enough of these scholarships?

17 MISS RIVARD: No.

18 COMMISSIONER GIRARD: You could use more?

19 MISS RIVARD: Yes, we would like to have  
20 more because we have had two at the maximum and that  
21 is not enough.

22 COMMISSIONER GIRARD: This comes back  
23 to my previous question, you would like to train your  
24 nurses still further. In other words, you would accept  
25 all scholarships that were offered to you?

26 MISS RIVARD: Well, for rehabilitation  
27 courses the Polio Organization allows us to send our  
28 nurses to training schools and take this special course.

29 COMMISSIONER GIRARD: Do you have any  
30 nurses in training now?

MISS RIVARD: Yes, we have nurses in the  
public health school and we hope to send nurses to the  
rehabilitation centre and also a public hygiene school.





Guertin

8349

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4 Naturally the demand for rehabilitation training is  
5 growing and we do not have enough facilities to train  
6 our nurses in this field.

7 COMMISSIONER GIRARD: Now, a few  
8 questions concerning your affiliated organizations. I  
9 use the word "affiliated" but perhaps you do not  
10 consider them as affiliated organizations. I would  
11 like to know about your relations with the societies  
12 for visitors which exist elsewhere in the province.  
13 What is your overall structure in these organizations,  
14 are they subordinate to your organization or what is  
15 their role? Are they truly affiliated organizations  
16 or subsidiary organizations?

17 MR. GUERTIN: No, they are not affiliated  
18 organizations because this implies a relationship of  
19 employer-employee. No. We should bear in mind that  
20 public care in the french population of Quebec requires  
21 an organization which is distributed within the  
22 diocese. Our association receives almost all its funds  
23 from the federation of charities but the other  
24 organizations receive their funds from other organizations  
25 and this implies a certain autonomy. There are sections  
26 in Montreal which maintain training schools, there are  
27 visiting nurse services in the Province and these groups  
28 have not sent nurses to undertake specialized training.  
29 There are very few of such services which have not  
30 received one of our own nurses in Montreal in order to  
provide supervisory service. Does this answer your  
question?

COMMISSIONER GIRARD: In Appendix D of







Guertin

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3 your brief you state that 7% of your income is derived  
4 from -- 92% of your service is provided from public  
5 funds and the rest is 7% which is furnished by patients  
6 who receive the service. Can you compare this 7% with  
7 the figures received from other organizations? This  
8 figure seems rather low to me.

9 MR. GUERTIN: I believe that we must  
10 bear one aspect in mind from the beginning, mainly,  
11 our society is affiliated with the federation of  
12 Catholic charities of French Canada and this means that  
13 most of our care is given to needy cases, cases who  
14 cannot pay for treatment. Naturally there are rates  
15 prevailing but the greater demand for our service comes  
16 from needy cases.

17 COMMISSIONER GIRARD: Do you feel it  
18 would be a good thing for the population to know that  
19 there is a visiting nurse association ready to provide  
20 care to other categories of the population other than  
21 the needy and to people who are able to pay. Do you  
22 recognize the fact that there are people who need such  
23 care and are able to pay for it?

24 MR. GUERTIN: We try to a limited extent  
25 to transmit this message you have just stated to the  
26 population and whenever possible we stress this fact  
27 that our service is available to the entire population,  
28 even those who can afford to pay. Of course, it is  
29 natural that when a needy case comes into a position to  
30 pay for care he will receive a bill. However, the  
medical journals receive publicity from our society, we  
make ourselves available to doctors. I believe we have







Guertin

8351

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3 been listed in the registry as a patient care service.

4 COMMISSIONER GIRARD: Well, I think it  
5 would be unwise to use the nurses for special services.

6 MR. GUERTIN: Well, we are also of the  
7 same opinion. The demand for our service comes  
8 particularly from those who require our services and  
9 are not able to pay.

10 MISS RIVARD: I think that this is a  
11 matter of customary practice. Many people are more  
12 inclined to call a doctor when they need treatment  
13 rather than applying to a nursing society. Perhaps  
14 this has not become the practice here in French Canada.

15 COMMISSIONER GIRARD: Thank you very  
16 much.

17 COMMISSIONER BALTZAN: I must say from  
18 what I have heard, ladies and gentlemen, that you are  
19 truly a voluntary and charitable organization, at least  
20 92%. I have a few simple questions. My first question:  
21 What are the charges per visit when people are able  
22 to pay, have you established that?

23 MR. GUERTIN: Well, that depends on the  
24 care provided, we have different care which requires  
25 more time, rehabilitation, for instance, will take much  
26 more time than simply an injection upon a doctor's  
27 prescription.

28 COMMISSIONER BALTZAN: And when people  
29 are unable to pay what is your method of knowing or  
30 finding out that they are not in a position to pay?  
Have you any particular test or some other way of  
defining it or do you just simply take their word?





Guertin

8352

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4 MR. GUERTIN: No, there are certain  
5 records in Montreal of persons who are assisted in  
6 one way or another because everywhere there are  
7 chronic indigents, needy people who are known. There  
8 is each time a very careful survey made and there are  
9 cases where it is not paid for totally, its total value  
10 is partially paid for. We believe that most of these  
11 cases are worth nothing but if they get into a position,  
12 without committing a holdup, to pay, then they will  
13 be billed. We have constant concern over funds,  
14 administering these funds which come from public  
15 charity. We depend on public charity and we must not  
16 use those funds in just any way. We are aware of this  
17 and we check and recheck as to the ability of the  
18 patient to pay or not to pay for the care which he  
19 receives.

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20 COMMISSIONER BALTZAN: In other words,  
21 these people actually declare themselves as unable to  
22 pay and so there is not too much difficulty then in  
23 respect to these cases. You have not what is popularly  
24 known as a means test for these people?

25 MR. GUERTIN: I do not know what you  
26 mean by a means test.

27 THE CHAIRMAN: A survey?

28 MR. GUERTIN: Yes, that is so, it is a  
29 means test.

30 COMMISSIONER BALTZAN: Would you tell  
me are there any home maternity services conducted in  
your area by your nurses?

MR. GUERTIN: Yes, our brief mentions this.







Guertin

8353

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4 Incidentally, it is a situation which we have just  
5 inherited, a very old agency which began, I believe,  
6 at the beginning of the last century which took care  
7 of all care for childbirth in the home. A study was  
8 made to regroup the work which can be done to avoid  
9 duplication with excessive costs. There is still this  
10 childbirth at home in spite of the fact the care is  
11 probably better at the hospital. Of course, these  
12 cases are decreasing and quite rightly so. There must,  
13 unfortunately, be a service available to those persons  
14 who have no other means open to them but it is a very  
15 costly service from our point of view.

C/AG/hm 14 COMMISSIONER BALTZAN: You must excuse  
15 me, some of the answers to the questions I ask may be  
16 in the body of the brief, but they came to me rather  
17 late.

18 You speak considerably of saving the  
19 hospital days per patient. The more you save in the  
20 way of hospitalization by way of rendering home  
21 services the less costly it is going to be for the  
22 population, and the services, I expect, will be just  
23 as good. Sometimes one asks the question of this  
24 emphasis upon saving a hospital day just simply  
25 because of the cost, and wonders about a recent  
26 tendency to do this saving, as against the former days,  
27 when it was very difficult to get patients into the  
28 hospital. Now it seems to be hard to get them out of  
29 the hospital. Now, are we going a little bit against  
30 modern day scientific treatment by hurrying patients  
out of the hospital, considering the dollar in advance







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3 of the most scientific treatment? Always the question  
4 is all through the country emphasis upon saving a  
5 day at so many dollars, and less do we hear about the  
6 kind of specialized service which might accelerate  
7 the patient's improvement by keeping him an extra day  
8 in the hospital.

9 MR. GUERTIN: It would seem that what  
10 you have just mentioned at the end of your statement  
11 was no longer a problem. People would like to stay  
12 in hospital, but on the other hand if you consider  
13 the recommendations in our brief, it is explicitly  
14 and emphatically stated there that all this must be  
15 done on condition that it is not liable to cause any  
16 harm to the patient, and it is the medical authorities  
17 who must determine whether it is to the advantage,  
18 not of the hospital, not of the public, but of the  
19 patient to send him out one day before. If he is  
20 convalescent he must be convalescent at home, but if  
21 he needs care he should be in the hospital, but  
22 convalescence with some care at home may be advantageous  
23 to the patient, at home with his family rather than  
24 in the hospital. But technically perfect though it may  
25 be, however it is somewhat sterile from the point of  
26 view of human relations. The patient is completely  
27 outside his milieu, outside his family, and we feel  
28 there is something like atmosphere generally which  
29 will psychologically help the patient. It may not be  
30 a bad thing for him to have to be sent back to his  
own milieu, to his own family, and be trained again  
to become an autonomous person,





Guertin

8355

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3 and not someone who is served hand and foot.

4 COMMISSIONER BALTZAN: That is exactly  
5 the reason why I put the question, because I would  
6 like to have, and have got your very complete and  
7 thorough reply with the proper emphasis.

8 COMMISSIONER VAN WART: Mr. Guertin,  
9 have your staff found a complaint among the patients  
10 who have been discharged from the hospital and come  
11 into your home care plan, that they do not want to  
12 pay your fee, feeling that they have been sent out of  
13 the hospital where they have been getting free treatment?

14 MR. GUERTIN: Your question is an  
15 interesting one, but I think that our relations as  
16 Societe des Infirmieres Visiteuses with the hospital  
17 where a private project is going on has not been quite  
18 understood.

19 We charge the hospital so much by visit  
20 from our nurses on request by the hospital to follow  
21 up a patient, so it is not a question of payment by  
22 the patient. The hospital sees to that, and I don't  
23 know what their relations with the patient are in that  
24 regard, whether there is a bill or fees or doctor's  
25 fees, or otherwise. I am unaware of that, but it is  
26 the hospital who sees to that. We receive monthly  
27 remuneration for the number of visits which we carry  
28 out each month.

29 COMMISSIONER VAN WART: Are the nurses  
30 receiving any objection from the patients towards  
payment of that fee?

MR. GUERTIN: We haven't heard anything of th







Guertin

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1 yet, whether it does occur.

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4 COMMISSIONER FIRESTONE: Mr. Guertin,  
5 you refer in the third paragraph on page 16 to the  
6 importance of providing drugs to indigent patients.  
7 Can you explain to us how an indigent person in the  
8 Province of Quebec can obtain drugs now?

9 THE CHAIRMAN: That is outside the  
10 hospital.

11 COMMISSIONER FIRESTONE: Outside the  
12 hospitals, and these are drugs prescribed by a  
13 physician.

14 MR. GUERTIN: I think this aspect is  
15 covered exclusively by charity organizations, such as  
16 the Association St. Vincent de Paul, and others. There  
17 is no precise center which deals with what you are  
alluding to.

18 COMMISSIONER FIRESTONE: If a person is  
19 sick, if I may just restate the question, if a person  
20 is sick and he sees a doctor, and the doctor prescribes  
21 certain drugs, and the person says: "Doctor, I have  
no money to buy the drugs". What does he do?

22 DR. TRUDEL: It is on the basis of  
23 certain considerations which were stated here that I  
24 added the paragraph on page 16. What is consistently  
25 done is that whether in orthopaedics or in neurology  
26 we are obliged to give treatment of long duration to a  
27 patient, take a case of epilepsy for instance. The  
28 patient is given a three-month treatment. It is not  
29 necessary to keep him in hospital for three months.  
30 After three months he comes back to us for checking. As







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3 regards orthopaedics and osteomyelitis for instance,  
4 there are patients who must have antibiotics which  
5 are expensive. We have cases, we have many cases in  
6 fact, where we keep the patient at hospital under the  
7 present hospitalization insurance plan, and the hospital  
8 gives the drugs as long as he is in the hospital,  
9 particularly in the case of children and the child is  
10 hospitalized. When he goes back home the hospital is  
11 no longer obliged to give the drugs. The drugs are  
12 expensive, and he may have to have them two weeks,  
13 three weeks, a month, under medical control of course,  
14 and in many cases it has happened that we have kept  
15 the patient in the hospital for one week or ten days,  
16 so it costs \$20.50 per day for medication, which is  
17 very much lower than that cost if we kept him longer  
18 to give him the proper drugs. It would cost the  
19 government a lot of money, whereas if the government  
20 would pay for the drugs after discharge when they are  
21 absolutely necessary, I am quite sure it would not  
22 come to the rate of \$20.50 per day, and I think there  
23 are several hospitals in that case.

24 COMMISSIONER FIRESTONE: I understand  
25 sir, and I would like to pursue this point a little  
26 further before returning to my original question. On  
27 the point which you just made, Doctor, do I understand  
28 that physicians will keep patients longer in the  
29 hospital in order to make sure that he obtains the drugs  
30 which he might otherwise not obtain. Is this the going  
practice in the Province of Quebec?

DR. TRUDEL: Yes, I was so informed by  
a physician, because the antibiotic was absolutely





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3 necessary. When we begin treatment by antibiotics,  
4 when you have begun it you cannot stop it if the  
5 disease has not been arrested. The drugs are paid  
6 for by the hospitals as long as the child is hospitalized,  
7 and when the child is no longer hospitalized, if the  
8 hospital pays for it the hospital takes the money from  
9 its own funds, but no longer gets the money from the  
10 government.

11 COMMISSIONER FIRESTONE: In other words,  
12 you feel sir that if the system were changed whereby  
13 drugs would be paid for after the patient returns home,  
14 that this would in effect mean a substantial saving  
15 to the operation of the hospital insurance programme.  
Is that the point you are making sir?

16 DR. TRUDEL: Yes, that is correct.

17 COMMISSIONER FIRESTONE: And would your  
18 group feel that this would be a desirable arrangement  
19 to work out for governments to provide drug services  
20 prescribed by physicians after these patients leave,  
in order to shorten hospital stay?

21 DR. TRUDEL: I think it would shorten  
22 the hospital stay in many cases, and by several days  
23 sometimes.

24 COMMISSIONER FIRESTONE: And it would  
25 therefore save costs to the government and the  
26 Canadian taxpayer?

27 DR. TRUDEL: There is a big saving in  
actual money, because you pay \$20.00 a day for antibiotics.

28 MISS RIVARD: In the pilot plan mentioned  
29 earlier drugs were also included, because the project  
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Guertin

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provides that the drug will be supplied to the patient at his home.

COMMISSIONER FIRESTONE: May I now come back to the original question. How are drugs obtained by a person that is indigent, cannot pay for it? He sees a doctor, the doctor says: "You have pneumonia, you must have this drug to get well", and the patient says: "Sorry Doctor, I have not the money". What happens to that patient? He is at home, the doctor has seen him and prescribed drugs. What happens to that man? Does he stay in bed and have no drugs?

MR. GUERTIN: First there are various types of indigent. He is an indigent, he cannot pay. Right. If he is purely temporarily indigent there are private charity organizations which can meet that case. We have those everywhere. Of course it is not very flexible nor easy as a system. I don't think it can be stated that in a center such a Montreal or other centers in the Province of Quebec, somebody dies because he cannot afford drugs. I don't think that exists. If he is recognized as an indigent and benefiting from the City Welfare Services, the Welfare Service will see to acquiring the required drugs or medicines and pay the cost for them. That is what is done. You have in cases of cancer, in those cases that our association may receive, as mentioned in our brief we receive certain gifts from the Canadian Cancer Society, which permit us to have the necessary drugs for those people.

COMMISSIONER FIRESTONE: Let us take the







Guertin

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4 example which you mentioned, the welfare case, somebody  
5 who is in receipt of welfare payments. What does  
6 that person do to get drugs? He is sick at home, the  
7 doctor has prescribed drugs. What does that person  
do?

8 MISS RIVARD: That patient, if we are  
9 called to go and treat that patient and he cannot  
10 obtain the drugs, our service will take the necessary  
11 action to obtain them for him. Either we make a  
12 supplementary request from the City Welfare Society,  
13 or we communicate ourselves with the St. Vincent de  
Paul Society of his parish, or other benevolent  
14 organizations which exist, or if it is a cancer case  
15 we do not have very much of a problem, because we have  
16 gifts, as Mr. Guertin said, which are definitely  
17 applicable to certain types of medicines, but in other  
18 cases, in some clinics I think for instance if the  
19 doctor is attached to the clinic there are means of  
20 obtaining drugs for a limited time, but if the treat-  
21 ment is to be continued it becomes much more complicated.  
22 In general however I don't think that there are very  
many patients who remain without drugs.

23 MRS. JACOBS: We usually make the  
24 request of the social service of the cities, and they  
25 give, they authorize a further amount than what is  
26 usually received by the patient, in order to pay for  
those drugs.

27 COMMISSIONER FIRESTONE: I understand  
28 from you that a patient that asks you ladies to come  
29 in and help him out is a fortunate patient, because you  
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Guertin

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3 make the arrangements for him. Now, what happens if  
4 he is not fortunate enough to call you, and he still  
5 needs drugs?

6 MR. GUERTIN: Possibly Dr. Trudel might  
7 answer that better than I can, because I think that  
8 this is where the whole machinery starts. If the need  
9 is found by the physician, and I think that our doctors  
10 practising here know how those drugs may be obtained in  
11 a case of need.

12 DR. TRUDEL: As regards Ste. Justine's  
13 Hospital, and I think this is practised more or less  
14 everywhere in hospitals, we receive patients who are  
15 poor, we receive them in the out-patient's departments,  
16 and those who do not have the initiative to come to  
17 the out-patient's services may be helped by certain  
18 organizations in their parishes, at least when it is  
19 known. Now, every day from time to time we see by  
20 the papers that there was a case of a needy person who  
21 didn't have the initiative of consulting a doctor or  
22 going to the hospital, but today I think in the present  
23 circumstances there are not very many people who  
24 cannot quite openly call upon bodies such as the  
25 hospital. They are then seen by the doctor, and the  
26 doctor knows whether they need drugs or not, and so  
27 prescribes. I think the cases who do not take  
28 advantage of that are very rare.

29 COMMISSIONER FIRESTONE: If the patient  
30 comes to the out-patient clinic of the hospital and the  
31 doctor's diagnosis requires that he obtain certain  
32 drugs, are these drugs provided by the hospital free







Guertin

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3 of charge to an indigent person?

4 PB/hm DR. TRUDEL: Yes and no, sir. At present  
5 the outside care is not covered by hospitalization  
6 insurance. It has been mentioned that out-patient  
7 services would be covered in April, but in the present  
8 state of affairs it is the hospital which gives the  
9 drugs to those who cannot pay, and not only for my  
10 hospital, but I think elsewhere it is much the same,  
11 where the patients from, more or less everywhere, if  
12 they are needy people it is the hospital which meets  
13 the needs of the drugs. We have to find the means  
14 of compensating for that. As for the others, those  
15 who can give something will then pay at the cost  
16 price. That is the best we can do.

17 COMMISSIONER FIRESTONE: I understand  
18 you are providing, hospitals in the Province of Quebec  
19 are providing drugs to indigents without them paying  
20 for it since they are not in the position to do so, but  
21 the hospital is not reimbursed by the government for  
22 the drugs that they dispense; is that correct?

23 DR. TRUDEL: That may be pushing a little  
24 far. I think as I said earlier the out-patient  
25 services are not covered by the hospital insurance, and  
26 as to whether Governments have given anything in any  
27 certain areas to cover these expenditures, I don't know,  
28 but I think it is not done habitually. In the Ste.  
29 Justine Hospital when we give \$25.00 worth of drugs for  
30 two weeks it is the hospital that pays for it.

COMMISSIONER FIRESTONE: Now, sir, and  
this question is addressed to Mr. Guertin as well as  
anyone else who wishes to deal with it, how do you feel,







Guertin

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4 can this system which is more or less a hit or a miss  
5 arrangement be improved so the drugs could be  
6 provided on a continued basis to indigent people  
7 without having to rely on charity or goodwill of the  
8 hospital or what have you? Is there some suggestion  
9 you have as to how this system could be improved? I  
10 think on page 16 you had in mind the improvement of  
11 this system. Would you specify what you mean?

12 MR. GUERTIN: We have had very short  
13 experience of only a few months in which this would  
14 apply. That is required drugs are made available to  
15 supply at the time when they are needed, and we find  
16 for the patient, and generally speaking the public,  
17 in the long term this might be advantageous because  
18 there is this very charitable donation of hospitals  
19 to patients, so he can obtain treatment for his  
20 disease including expensive drugs, and hospitalization  
21 is the only decent way of doing it. We take the only  
22 means at our disposal to avoid that. These cases  
23 are rather numerous, so it means a large number of  
24 days of board and hospital care at the hospital. It  
25 might have a tendency to be able to replace that by  
26 giving the drugs which the needy person cannot procure.  
27 Does that answer your question?

28 COMMISSIONER FIRESTONE: Would you feel  
29 then, Mr. Guertin, when the hospital dismisses a  
30 patient part of this hospital coverage should include,  
not only the hospital stay and the drugs while at  
the hospital but the drugs required to complete this  
treatment after the patient leaves the hospital so  
that you would have the whole operation covered rather





Guertin,

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4 than only up to the point where the patient leaves  
5 hospital?

6 MR. GUERTIN: If the stay requires  
7 treatment -- in reply to your question it is obvious  
8 that it should be completed in the same condition in  
9 which it was started, particularly if the fact of  
10 discharge might cause the treatment to cease because  
11 of the indigence of the patient.

12 COMMISSIONER FIRESTONE: Therefore you  
13 would be in favour of including your costs after the  
14 patient leaves the hospital covering drugs prescribed  
15 by the physician required to complete the treatment.

16 MR. GUERTIN: Absolutely.

17 COMMISSIONER FIRESTONE: Now, I am  
18 coming back to the question raised a little earlier,  
19 would you also recommend that drug cost be covered  
20 for patients at out-patient clinics of a hospital?

21 MR. GUERTIN: This is somewhat outside  
22 our own competence, but as a citizen interested after  
23 all in the provision of health at the best possible  
24 conditions, I would answer yes to your question  
25 because I think it would be the means of having parties  
26 hospitalized which would otherwise be unnecessary.

27 COMMISSIONER FIRESTONE: Would you  
28 care to offer any comment on that question, sir?

29 DR. TRUDEL: I agree with Mr. Guertin.  
30 It is somewhat outside our competence but we would  
be desirous for indigents to have some practical help  
from the Provincial Government.

COMMISSIONER FIRESTONE: Thank you very





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COMMISSIONER FLETCHER: Would you

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DR. THURTELL: I agree with Mr. Gurrin.

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be desirous for indigents to have some practical help

from the Provincial Government.

COMMISSIONER FLETCHER: Thank you very



Guertin

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much gentlemen and ladies.

THE CHAIRMAN: Only one question. On page 15 you state in 1961 there was 835,000 patients and you say the Government of the Province has paid hospitalization in the amount of \$142 million. Is this amount the total cost or only the half paid by the Province?

MR. GUERTIN: The statement from which we drew that figure was made by the Prime Minister on the 22nd of February. We have made use of that figure. It becomes more important in proving our point if that represents only half. I don't know whether it is half or the whole.

THE CHAIRMAN: It is an important point.

MR. GUERTIN: If it is half and the total is \$284 million I think that doubly proves our point.

THE CHAIRMAN: You know on hospitalization the governments share half and half almost.

Well, thank you very much Mr. Guertin and your colleagues. You have given us most useful information. We will take a short recess.

---Short recess.

THE CHAIRMAN: We will come to order now and have the submission of the College Des Medecins et Chirurgiens de la Province de Quebec.







SUBMISSION OF  
COLLEGE DES MEDECINS ET CHIRURGIENS DE LA  
PROVINCE DE QUEBEC

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APPEARANCES:

Dr. A. Rioux  
Dr. Bonin  
Dr. Ward  
Mr. Thomas Boudreau  
Dr. Gagnon  
Dr. Arthur Fafard  
Dr. George Lachaine

DR. WARD: We are pleased to welcome the members of this Commission. I will introduce the members of our delegation. On my left is Dr. George Lachaine, second vice-president of the college; Dr. Arthur Fafard, first vice-president; Dr. W. Bonin, Dean of the Faculty of Medicine of the University of Montreal; Dr. Armand Rioux; Dr. Thomas Boudreau our economist at the College of Physicians and Surgeons and Dr. Gagnon, a member of the committee. I will ask Dr. Gagnon to read the eight pages of this summary which will be found on page 1 of our brief.

THE CHAIRMAN: Thank you very much.

DR. RIOUX: The Members of the Medical profession of the Province of Quebec are happy to welcome the Royal Commission we are appearing before, the eminent citizen who was born in the country of North River. I am also happy in the choice of the commissioners to assist him because they were selected among the most qualified and competent in the profession. Considering the man's need of women, the love of the patient, men couldn't deal with this without her counsel. We are delighted to have her here.





Rioux

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We rejoice ourselves in her. We will present our brief, and insofar as possible, we have a limited time before us, unfortunately, and we haven't been able to consult on the question which involves not only the report but the whole future of the medical profession. In the brief we have attempted to be very modern and taking a count of the experience of certain countries already in state medicine. I will read the brief.

### RÉSUMÉ

R-1. Le Collège des médecins et chirurgiens de la province de Québec est un corps constitué par une loi, dont doivent être membre tous les médecins qui désirent exercer leur profession dans la province de Québec. A ce titre, le Collège des médecins considère donc comme étant d'importance primordiale toute recherche, tout démarche visant à améliorer la qualité et la distribution des services de santé dans la province.

R-2. Nous basant cependant sur des textes de L'Acte de l'Amérique du nord britannique, sur l'esprit de la Confédération et sur des arguments d'ordre logique, nous réaffirmons ici que le domaine de la santé est du ressort exclusif des provinces. Il est par ailleurs évident que le secteur de la santé est devenu l'un des postes les plus importants des budgets gouvernementaux, et le champ d'action des gouvernements dans le domaine de la santé est probablement appelé à s'élargir davantage au cours des prochaines années. Nous ne voyons par conséquent pas comment l'immixtion progressive du gouvernement fédéral dans des domaines qui constitutionnellement ne lui sont pas dévolus, pourra prendre fin sans que s'effectue enfin ce partage réaliste et équitable







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3 de l'assiette fiscale que le Québec réclame depuis si  
4 longtemps. Dans la situation actuelle, le choix qui  
5 continuellement se pose à la province de Québec, comme  
6 d'ailleurs aux autres provinces, est, ou bien de  
7 sacrifier une partie des ses prérogatives constitution-  
8 nelles, ou bien de se priver de mesures sociales devenues  
9 nécessaires.

10 R-3. Il sera loisible à la Commission de  
11 juger de l'entendue de certains de nos besoins en  
12 matière de santé et de constater que nos demandes pour  
13 des ressources provinciales plus abondantes correspondent  
14 à des nécessités incompressibles.

15 R-4. Considérant la longueur et la difficulté  
16 des études de médecine et la courte période de vacance  
17 accordée l'été aux étudiants, il est devenue  
18 indispensable à notre avis d'assister financièrement  
19 les étudiants en médecine si nous voulons maintenir la  
20 qualité et la quantité des candidats.

21 R-5. La formation et le recrutement des  
22 professeurs pour nos facultés de langue française  
23 présentent également de nombreuses difficultés étant  
24 donné que le réservoir où nous pouvons puiser se résume  
25 presque exclusivement à la province de Québec. Ici  
26 encoure nous croyons qu'une assistance financière sous  
27 forme de bourses aiderait à remplir nos cadres.

28 R-6. Une étude de l'évolution future de  
29 l'offre de nouveaux médecins dans le Québec montre que  
30 la fondation d'une future faculté à l'université de  
Sherbrooke est nécessaire si l'on désire réaliser une  
légère amélioration de la proportion médecins/population







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4 d'ici 1977 environ. Or, considérant les diverses régions  
5 de la province où il y a présentement un manque de  
6 médecins, et la volonté de la profession médicale et  
7 de la société en général de rendre les soins médicaux  
8 d'un accès aussi facile que possible, nous considérons  
9 que cette légère amélioration du rapport médecins/  
10 population est un minimum nécessaire. Il faudra donc  
11 pour la province de Québec, construire cette nouvelle  
12 faculté et en plus y assurer un recrutement suffisant  
13 en étudiants et en professeurs.

14 R-7. Il existe présentement en médecine  
15 une tendance évidente vers la spécialisation. Cette  
16 tendance se maintiendra probablement encore pendant des un  
17 certain nombre d'années. La diminution proportionnelle con  
18 des praticiens généraux ne peut donc manquer de

19 soulever certains problèmes. Nous croyons à cet égard  
20 qu'il est devenue indispensable d'assurer aux généralistes  
21 des conditions de travail aussi favorables que possible  
22 afin d'éviter d'une part que cette composante  
23 essentielle de la profession ne vienne à disparaître  
24 et afin d'utiliser d'autre part, avec un maximum  
25 d'efficacité, cette ressource proportionnellement plus  
26 rare. Parmi les choses que nous considérons comme  
27 constituant des conditions favorables de travail pour  
28 les praticiens généraux, l'accès facile aux hôpitaux  
29 est la plus importante.

30 R-8. Une étude de la distribution  
géographique des effectifs médicaux à travers la  
province laisse voir très clairement que certaines  
régions, éloignées des grands centres, et économiquement  
plus faibles, sont beaucoup moins bien pourvues en  
médecins que le reste de la province. Nous songeons





ici tout particulièrement aux régions de la Gaspésie, de l'Abitibi et de la Côte nord. Nous croyons que c'est là un problème à la solution duquel le gouvernement et la Collège des médecins doivent s'attaquer conjointement. Nous croyons que si le gouvernement de la province offrait une rémunération de base aux médecins consentant à s'établir dans ces régions relativement isolées, il serait possible de résoudre le problème. Cette rémunération de base permettrait à ces médecins de venir régulièrement vers les grands centres afin d'assister à des réunions ou congrès scientifiques et de se tenir au courant des derniers développements techniques et scientifiques.

R-9. Les hôpitaux pour malades chroniques nous semblent représenter un secteur où il y aurait grand profit à effectuer une certaine réorganisation. Une spécialisation plus poussée au sein de ces institutions nous apparaît désirable. Il faudrait songer aussitôt que possible à loger les vieillards et les incurables ne nécessitant que des soins de garde dans des foyers d'accueil. Les hôpitaux pour chroniques seraient ainsi réservés aux malades chroniques dont l'état exige des soins plus intensifs et deviendraient ainsi de véritables hôpitaux où la qualité des soins devrait se maintenir au niveau de celle des hôpitaux généraux.

R-10. Exception faite de la province de Terre-Neuve, c'est au Québec que l'on trouve la plus basse proportion de lits d'hôpitaux généraux par 1,000 habitants. Notre déficit en ce domaine est d'environ







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4 20% par rapport au reste du Canada. Depuis l'avènement  
5 de l'assurance-hospitalisation, la période d'attente  
6 qui précède l'admission à l'hôpital, pour les cas qui  
7 ne sont pas considérés comme urgents, s'est  
8 considérablement prolongée. De plus, de nombreux  
9 médecins éprouvent des difficultés sérieuses à être  
10 admis pour fins de pratique dans les hôpitaux. Nous  
11 considérons donc qu'il est devenue nécessaire d'utiliser  
12 nos précieuses ressources hospitalières de la façon  
13 la plus efficace et la plus économique possible et en  
14 même temps de songer à augmenter ces ressources.  
15 L'utilisation de l'hôpital général devient en fait de  
16 plus en plus étendue et diversifiée. Les dix ou quinze  
17 dernières années ont connu une augmentation considérable  
18 de l'utilisation des lits d'hôpitaux généraux pour les  
19 cas de maternité. La décennie que commence verra  
20 probablement une évolution du même genre relativement  
21 au traitement des maladies psychiatriques.  
22 R-11. La mortalité maternelle a toujours été  
23 un grave problème au Québec. Encore ici, les statistiques  
24 relatives à notre province sont beaucoup plus sombres  
25 que celles de l'ensemble du pays. Les causes princi-  
26 pales de cet état de chose nous sont présentement connues  
27 et nous considérons qu'il serait actuellement possible  
28 d'éliminer, ou tout au moins d'atténuer un certain  
29 nombre d'entre elles. Parmi les moyens d'améliorer la  
30 situation, mentionnons brièvement:

1. Des crédits plus abondants à la section  
d'hygiène maternelle et infantile du ministère  
provincial de la santé afin de permettre à  
cette section d'intensifier l'éducation







prénatale et d'encourager les consultations  
prénatales par les médecins traitants.

2. Un contrôle plus sévère sur les conditions de  
la pratique de l'obstétrique dans les  
hôpitaux privés de la province et les cliniques  
privées de maternité.
3. Un nombre plus considérable de spécialistes en  
obstétrique et gynécologie et une meilleure  
distribution de ces derniers.

R-12. Nous croyons que tout comme l'éducation  
et l'hospitalisation, les soins médicaux constituent un  
service essentiel auquel tous doivent avoir facilement  
accès en cas de besoin, sans limitations dues aux  
ressources pécuniaires, à la situation géographique,  
ou aux ressources préalables de santé. Or, de même  
qu'il existe actuellement, dans notre province, certains  
déséquilibres de distribution géographique qui font  
obstacle à une distribution parfaite des soins médicaux,  
il existe également certaines inégalités d'ordre  
financier qui font que les soins médicaux sont d'un  
accès moins facile pour les uns que pour les autres.  
Notre Collège a proposé certains éléments de solution  
en regard du problème de la répartition géographique  
des effectifs médicaux. Nous croyons également de  
notre devoir de proposer une solution au problème de  
l'inégalité financière devant les soins médicaux.

R-13. Nous croyons de plus que les propositions  
que fait ici l'ensemble de la profession médicale du  
Québec, son suffisamment réalistes et généreuses pour  
retenir l'attention.





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3 R-14. Ces propositions se fondent sur la  
4 constatation fondamentale et évidente qu'il existe dans  
5 le phénomène de la distribution des soins médicaux deux  
6 parties ou deux groupes essentiels, soit ceux qui  
7 dispensent les soins, c'est-à-dire la profession médicale  
8 et ceux qui reçoivent les soins, soit le public. Il  
9 peut sembler ridicule de rappeler de telles évidences  
10 mais il semble malheureusement que ce soit de celles  
11 que l'on a parfois tendance à oublier.

12 R-15. Le fonctionnement efficace de tout  
13 plan de distribution des soins médicaux exige une  
14 satisfaction minimum de la part des deux parties en  
15 cause. Cette satisfaction par ailleurs est fonction de  
16 certaines exigences légitimes que l'on ne peut ignorer  
17 sous peine de compromettre tout plan de distribution,  
18 si génial puisse-t-il être, par ailleurs. Ces  
19 exigences sont:

- 20 1) de la part du public: comme nous l'avons  
21 mentionné plus haut, le public est en droit  
22 de s'attendre à avoir accès facilement, et  
23 chaque fois qu'il en a besoin, à des soins  
24 médicaux de la meilleure qualité possible.
- 25 2) de la part des médecins: le médecin en tant que  
26 citoyen libre et homme de science est en droit  
27 de s'attendre à ce qu'on lui accorde un maximum  
28 de liberté et de confiance dans l'exercice de  
29 sa profession. Liberté d'appliquer des traitements  
30 de la nature et selon la quantité qu'il juge  
nécessaire, sans intervention d'organismes  
extérieurs à la profession, et liberté de travailler  
de la façon et dans la mesure qu'il juge





R-10. Les propositions se trouvent en la

constatation fondamentale et évidente de la réalité que  
le plan de la distribution des soins médicaux doit  
porter sur deux groupes essentiels, soit ceux qui  
disposent des soins, c'est-à-dire la profession médicale  
et ceux qui ne disposent pas des soins, soit le public. Il

est sembler évident de respecter de telles distinctions  
mais il semble néanmoins que ce soit de celles  
que l'on a parfois tendance à oublier.

R-11. Le fonctionnement efficace de tout

plan de distribution des soins médicaux exige une

satisfaction minimum de la part des deux parties en

cause. Cette satisfaction par ailleurs est fonction de

certaines exigences législatives que l'on ne peut négliger

sans peine de compromettre tout plan de distribution

et par conséquent l'état, son avenir. Ces

exigences sont :

1) de la part du public, comme nous l'avons

mentionné plus haut, le public est en droit

de s'attendre à une action satisfaisante, et

chaque fois qu'il en a besoin, à des soins

adéquats de la meilleure qualité possible.

2) de la part des médecins, le médecin en tant que

profession libérale et homme de science doit en droit

de s'attendre à ce qu'on lui accorde un maximum

de liberté et de compétence dans l'exercice de

sa profession. L'exercice d'application des principes

de la nature de celui-ci qu'il lui faut

respecter, sans interférence d'organismes

extérieurs à la profession, et libérer de toute

de la part de ceux qui assurent la



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compatible avec ses forces et sa compétence.  
Cette liberté implique évidemment le droit à  
une rémunération proportionnelle à la qualité  
et à la quantité de travail effectué.

R-16. Compte tenu de ces prérequis essentiels,  
voici donc un résumé schématique du plan que nous  
proposons.

R-17. Un organisme indépendant, soustrait à  
toute influence politique directe, et faisant fonction  
en quelque sorte de régie autonome de l'assurance-santé,  
devra être formé. Cette régie aura comme fonction  
essentielle d'administrer de façon autonome une loi  
provincial de l'assurance-santé, c'est-à-dire d'en  
surveiller l'application.

R-18. Ce plan devra présenter les  
caractéristiques suivantes:

- 1) que l'assurance-santé soit rendue accessible  
à tous.
- 2) tout plan vendu par une compagnie ou une  
mutuelle d'assurance-santé devra obligatoirement  
contenir un certain nombre de bénéfices minima,  
nommément: toutes les visites de médecin au  
bureau, à domicile ou à l'hôpital ainsi que les  
frais chirurgicaux et obstétricaux.
- 3) tout plan offert par une compagnie à un individu  
ou à un groupe d'individus devra également être  
disponible pour tout autre individu ou groupe  
désirant obtenir le même plan.
- 4) tous les plans d'assurance-santé vendus par les  
compagnies ou mutuelles devront être des plans







- du type "service", c'est-à-dire ne comportant pas de charges additionnelles pour le patient.
- 5) les bénéfices versés aux médecins en vertu de l'assurance-santé devront l'être conformément à un tarif d'honoraires unique pour toutes les compagnies ou mutuelles de la province et conformément au système de la rémunération à l'acte médical.
- 6) le tarif d'honoraires utilisé dans la province devra être celui approuvé par la "régie autonome" lequel devra être basé sur un tarif suggéré par le Collège des médecins et déterminé à la suite d'une entente avec le Collège.
- 7) dans le cas des personnes pour qui le paiement de la prime constituerait une charge trop lourde, le gouvernement devra en défrayer le coût.
- 8) la composition de cette régie autonome devra être représentative des diverses parties intéressées. Il devrait donc s'y trouver:
- des représentants de la profession médicale nommés par le Collège des médecins.
  - des représentants des compagnies et mutuelles d'assurance.
  - des représentants du gouvernement, et par conséquent, de la population.
- La représentation de chaque groupe devra être égale de sorte qu'aucun n'aura la majorité absolue.





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4 9) Le Collège des médecins devra conserver de  
5 façon exclusive tous les pouvoirs qu'il détient  
6 présentement, et en particulier celui de régler  
7 les problèmes de normes et d'éthique profes-  
sionnelles.

8 R-19. Au moment de la rédaction de la loi  
9 régissant l'assurance-santé, de la mise en marche du plan,  
10 ou encore de toute modification à ce plan, aucune partie  
11 ne devra procéder de façon unilatérale. Il faudra  
12 plutôt qu'à chacune de ces étapes, des consultations  
soient établies entre toutes les parties intéressées.

13 R-20. Une majorité des gouverneurs du  
14 Collège des médecins est d'avis que l'adhésion de la  
15 population au plan proposé plus haut devrait être  
16 facultative. Une minorité des gouverneurs est d'avis  
17 que l'adhésion à ce plan devrait être obligatoire.  
18 Tous cependant s'entendent pour s'opposer à un contrôle  
19 absolu de l'Etat sur la distribution des soins  
20 médicaux.  
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4 THE CHAIRMAN: Thank you. To our  
5 deep regret, late in the afternoon yesterday we  
6 received this brief and consequently it was not  
7 possible for the other commissioners as well as myself  
8 to study it in detail and to give to it the attention  
9 that it deserves. However, we can assure you that  
10 this document will be studied by our research depart-  
11 ment and by ourselves; we will give it our careful  
12 attention. In the meantime, we will do everything  
13 possible to furnish answers to the most urgent questions  
14 contained in the brief.

15 The first question: What are the  
16 requirements of the College for an immigrant physician  
17 who wishes to practise the profession of medicine in  
18 Quebec?

19 DR. BONIN: The first requirement  
20 is that he must be a Canadian citizen; we do not grant  
21 a licence to practise medicine in Quebec to a person  
22 who comes from abroad and who has not been recognized  
23 as a Canadian citizen. In other words, he must have  
24 lived for the required five years in Canada. Furthermore,  
25 our College makes an enquiry as to the places where  
26 this person has studied medicine and also as to those  
27 institutions where he has carried on his specialized  
28 work and if these institutions are recognized institu-  
29 tions the committee for admitting is less exacting in  
30 its requirements than it would be if he comes from  
places where the university was not of the highest  
quality. In such case the committee would require  
entrance examinations and clinical examinations to be







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4 performed by the candidate. As the general rule an  
5 immigrant who comes here and who has studied in a  
6 recognized institution which has a recognized  
7 curriculum, these persons are simply subjected to  
8 clinical examination similar to those administered  
to students.

9 DR. WARD: There is an exception made  
10 in the case of professors who are brought here for  
11 teaching purposes at our universities. They can come  
12 here and at once receive a temporary licence or rather  
13 a teaching licence and there are, I suppose, twenty  
14 or thirty such people who are holders of such licences  
15 in the province who have been brought here for teaching  
16 in the university. Until they are citizens they are  
17 not able to undertake the practice in the city or  
open an office.

18 THE CHAIRMAN: Could it be that an  
19 immigrant physician could go to another province and  
20 after one year he could take an examination of the  
21 Canadian Medical Council and then come to the Province  
of Quebec to practise? Is this possible?

22 DR. BONIN: Well, it is possible.  
23 Our college from the theoretical standpoint is opposed  
24 to this. We are opposed to this and some years ago  
25 we opposed the decision of the Council with respect  
26 to the practise of medicine in the Province of Quebec.  
27 Our College was also opposed to the bill which called  
28 for many standard medical examinations in the Province  
29 of Quebec. In order to be consistent we are not  
30 in favour of this. We are against this, we are opposed

performed by the candidate. As the general rule an immigrant who comes here and who has studied in a recognized institution which has a recognized curriculum, these persons are simply subjected to clinical examination similar to those administered to students.

DR. WARD: There is an examination made

in the case of professors who are brought here for teaching purposes at our universities. They can come here and at once receive a temporary licence or rather a teaching licence and there are, I suppose, twenty or thirty such people who are holders of such licences in the province who have been brought here for teaching in the university. Until they are citizens they are not able to undertake the practice in the city or open an office.

THE CHAIRMAN: Could it be that an immigrant physician could go to another province and after one year he could take an examination of the Canadian Medical Council and then come to the Province of Quebec to practise? Is this possible?

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4 to having the Medical Council of Canada allow physicians  
5 to come to Quebec to practise medicine on the basis of  
6 such examinations. There is a certain certificate  
7 issued which allows foreigners to pass examinations that  
8 are set up by the Medical Council of Canada and such  
9 physicians can come to us in Quebec if they so desire  
10 and our College at the present time is forced to accept  
11 them. We simply require them to pass a clinical  
12 examination of the kind you mentioned a minute ago. We  
13 accept this with reluctance because we are convinced that  
14 anything concerning medicine and health should be under  
15 the jurisdiction of the Province of Quebec.

16 THE CHAIRMAN: Now, with respect to  
17 specialists, what is your situation now prevailing with your  
18 provincial College and the Royal College of Canada?

19 DR. BONIN: Well, if you refer to the  
20 Act, included in the brief you will see it states that  
21 only in Quebec it has the law authorizing licencing of  
22 specialists. That is with respect to these physicians  
23 who wish to practise in the Province of Quebec, and this  
24 is covered by articles 84 and 85 in the Act. We are  
25 reluctant to grant the licence of specialists even when  
26 it is authorized by the Royal College of Canada. We  
27 support the provisions of this law. About ten years  
28 ago we began to issue our own certificates to specialists  
29 and we can ourselves authorize specialists to practise  
30 in Quebec.

G/hm 31 THE CHAIRMAN: On page 65, excuse me,  
32 I made a few notes last night. On page 65, paragraphs  
33 129 to 132, you speak of giving assistance to family  
34





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to come to Quebec to practice medicine on the basis of  
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DR. BOWEN: Well, if you refer to the  
Act, included in the brief you will see it states that

specialists. That is with respect to these physicians  
who wish to practice in the Province of Quebec, and this  
is covered by articles 54 and 55 in the Act. We are  
reluctant to grant the licence of specialists even when  
it is authorized by the Royal College of Canada. We  
support the provisions of this law. About two years  
ago we began to issue our own certificates to specialists  
and we are ourselves anxious specialists to practice  
in Quebec.

THE CHAIRMAN: On page 53, excuse me,

I have a few more questions. On page 53, paragraph  
139 to 140, you speak of giving assistance to family



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4 physicians, to make hospital facilities available to  
5 them. This is a very good measure, but it is not a means  
6 of helping his training. Do you have any other  
7 suggestions to facilitate his training period?

8 DR. RIOUX: Well, our brief does include  
9 a suggestion to the effect that the number of medical  
10 students will be sufficient beginning 1970. In the  
11 institutions in the province, particularly Laval  
12 University, there has been a reduction in the number  
13 of requests for admission, and this is a cause of  
14 concern for the medical profession, and is of course  
15 of concern to our College.

16 In our brief it is stated that in order  
17 for there to be an increase in the number of medical  
18 students, and in order to avoid such a decrease in  
19 medical students in 1970, we should make medical study  
20 as attractive as possible, and according to the results  
21 of an enquiry we conducted, we should avoid that a  
22 prospective medical student should expect some domination  
23 of his future career by the State.

24 Our College conducted a survey which  
25 led us to the conclusion that 15% of prospective  
26 candidates give up the idea of studying medicine because  
27 they are afraid of State control.

28 There is another factor, namely medical  
29 students cannot attain their objective. We also  
30 suggested that the State furnish some assistance here,  
perhaps scholarships, which would be given to students  
who require them, or perhaps loans be granted.

With respect to general medicine, the



physicians, to make hospital facilities available to them. This is a very good measure, and it is not a means of helping the training. Do you have any other suggestions to facilitate his training period?

DR. RICHY: Well, our belief was that

a suggestion to the effect that the number of medical students will be sufficient beginning 1970, in the institutions in the province, particularly in the University, there has been a reduction in the number of requests for admission, and this is a cause of concern for the medical profession, and is of course of concern to our College.

It was pointed out that in a few

for there to be an increase in the number of medical students, and in order to avoid such a decrease in medical students in 1970, we should take certain steps as alternative measures, and according to the results of an enquiry we conducted, we should avoid that a prospective medical student should expect some form of financial aid from the State.

Our College conducted a survey which

led us to the conclusion that the prospective candidates give up the idea of studying medicine because they are afraid of State control.

There is another factor, namely medical

students cannot attain their objectives. We also suggested that the State should give assistance to poor students, which would be given to students who require them, or perhaps loans be granted.

With respect to general medicine, the





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4 practitioner who receives his diploma should be able  
5 to practise his profession in the best possible way.  
6 For this reason we are in favour of giving these  
7 physicians the right to hospital facilities. For this  
8 reason the number of hospital beds should be increased,  
9 to attain this objective. For this purpose we have  
10 stated that in order for there to be an adequate number  
11 of hospital beds, and in order for the practitioner to  
12 be allowed to treat these patients, there must be an  
13 increase of 11,000 hospital beds in the province.

14 Furthermore sir in the Province of  
15 Quebec, as is stated in the brief, there are certain  
16 areas, isolated areas, which are sparsely populated,  
17 where fortunately or unfortunately the government of  
18 the province is required to assign certain sitters, or  
19 people to take care of patients at home. Now, such  
20 people in these remote areas should be given appropriate  
21 care. For this reason a physician who agrees to work  
22 for the health of patients in remote areas should  
23 receive subsidies from the State, that is from the  
24 Provincial Government of course.

25 THE CHAIRMAN: You mean assistance from  
26 the point of view of salary?

27 DR. RIOUX: Well, his basic salary will  
28 be provided by his fees, because we cannot conceive of  
29 a doctor working for 12 or 15 years and giving service  
30 to his fellow citizens without extracting a minimum of  
revenue, to allow him to live decently.

THE CHAIRMAN: Have you a figure in  
mind?



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Physicians the right to hospital facilities. For this reason the number of hospital beds should be increased to attain this objective. For this purpose we have stated that in order for there to be an adequate number of hospital beds, and in order for the practitioner to be allowed to treat these patients, there must be an increase of 11,000 hospital beds in the province.

Furthermore in the Province of Quebec, as is stated in the brief, there are certain areas, isolated areas, which are sparsely populated, where unfortunately or unfortunately the government of the province is required to assign certain citizens, or people to take care of patients at home. Now, when people in these remote areas should be given appropriate care. For this reason a physician who agrees to work for the health of patients in remote areas should receive subsidies from the State, that is from the Provincial Government of course.

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MR. KLOUX: Well, his basic salary will be provided by his fees, because we cannot conceive of a doctor working for 12 or 15 years and giving service to his fellow citizens without extracting a minimum of revenue, to allow him to live decently.

THE CHAIRMAN: Have you a figure in



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4 DR. RIOUX: We feel that the figure of  
5 \$5,000.00 would be adequate. This would be paid by  
6 the province.

7 DR. JOBIN: Mr. Chairman, I believe that  
8 Dr. Rioux replied only partially to the question you  
9 just raised. When you asked him to speak of continuing  
10 education he stressed the two means of assisting a  
11 physician to exercise his profession, namely by opening  
12 the hospitals up to him and also by enabling him to  
13 practise group medicine, but I should like to ask Dr.  
14 Rioux to answer the other question you raised, namely,  
15 what is the view of the College with respect to aiding  
16 future training of the family physician, or the general  
17 practitioner? Now of course, you have certain views  
18 on this point.

19 DR. RIOUX: Well, since this question  
20 concerns teaching, and since we have the Dean of the  
21 University of Montreal here, I will ask him to be kind  
22 enough to give the required information.

23 DR. BONIN: Mr. Chairman, we have two  
24 ways of assisting in the training of the general  
25 practitioner. First, several hospitals organize special  
26 studies. Furthermore, our hospitals invite specialists  
27 to attend various scientific meetings. They meet  
28 sometimes every Saturday morning, and this is what is  
29 done in the larger cities to assist in the training  
30 with respect to this type of continuing education.

THE CHAIRMAN: I refer now to page 85.  
It is recognized that the general hospitals are rather  
costly. Have you organized home medical services for





25,000.00 would be adequate. This would be paid by the province.

Dr. Rioux replied only partially to the question you just raised. When you asked him to speak of continuing education he alluded to the two means of assisting a physician to exercise his profession, namely by opening the hospitals up to him and also by enabling him to practise group medicine, but I should like to ask Dr. Rioux to answer the other question you raised, namely, what is the view of the College with respect to aiding future training of the family physician, or the general practitioner? How, of course, you have certain views on this point.

Dr. Rioux: Well, since this question concerns teaching, and since we have the Dean of the University of Montreal here, I will ask him to be kind enough to give the required information.

ways of assisting in the training of the general practitioner. First, several hospitals organize special studies. Furthermore, our hospitals involve specialists to attend various scientific meetings. They meet sometimes every Saturday morning, and this is what is done in the larger cities to assist in the training with respect to this type of continuing education.

THE CHAIRMAN: I refer now to page 85.

It is recognized that the general hospitals are rather costly, have you organized some medical services for



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3 chronic diseases and for convalescence?

4 DR. RIOUX: Mr. Chairman, unfortunately,  
5 as is stated in the brief, unfortunately there are no  
6 such services in the Province of Quebec. We do not  
7 have any convalescent hospitals here at the present  
8 time. Certain organizations in the psychiatric field  
9 do such work, but the patients remain in the hospital  
10 for only a limited period of time.

11 We have stressed in our brief the need  
12 for hospitals having special sections for convalescent  
13 patients, and thus those patients can be cared for  
14 outside the general hospital, and these sections can  
15 deal with those patients who have to wait sometimes  
16 as much as a month before receiving hospital care.

17 We have a whole chapter concerning  
18 chronic patients. We also have a section dealing with  
19 the treatment of the aged. In Quebec we have certain  
20 homes, or certain institutions, which receive both  
21 chronic patients, patients suffering from chronic  
22 diseases, and aged patients. We believe that those  
23 patients which cannot be cured should be placed in  
24 appropriate institutions. We feel that it is particularly  
25 women who suffer from this lack of bed space in the  
26 hospitals. There is one particular institution in  
27 Quebec, quite recently built, which handles men only.  
28 However, women do not have enough facilities available  
29 to them in the hospitals for chronic diseases.  
30 Therefore it is highly urgent for us to give attention  
to this matter.

We have given thought to the fact that



chronic diseases and for convalescents?

DR. RICHARD M. CHAMBERLAIN, M.D., Chairman, University of Toronto

As is stated in the brief, unfortunately there are no such services in the Province of Quebec. We do not have any convalescent hospitals here at the present time. Certain organizations in the psychiatric field do some work, but the patients remain in the hospital, for only a limited period of time.

We have expressed in our paper the need for hospitals having special sections for convalescent patients, and thus those patients can be cared for outside the general hospital, and these sections can deal with those patients who have to wait sometimes as much as a month before receiving hospital care. We have a whole chapter concerning

chronic patients. We also have a section dealing with the treatment of the aged. In Quebec we have certain homes, or certain institutions, which receive both chronic patients, patients suffering from chronic diseases, and aged patients. We believe that those patients which cannot be cured should be placed in appropriate institutions. We feel that it is particularly women who suffer from this lack of bed space in the hospital. There is one psychiatric institution in Quebec, quite recently built, which handles men only. However, women do not have enough facilities available to them in the hospitals for chronic diseases. Therefore it is highly urgent for us to give attention to this matter. We have also thought to the fact that





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4 aged people are overlooked in certain institutions  
5 where they should be accepted. There should be homes  
6 for them in the Province of Quebec. There are certain  
7 such homes. I do not say that there are none, but we  
8 have the impression that they are not sufficient in  
9 number, and we hope that in the course of time in  
10 certain regions there will be small centres, small  
11 homes, which will receive aged people, who for material,  
12 financial reasons cannot find acceptance elsewhere.

13 THE CHAIRMAN: I now refer to page  
14 115. You mention here in paragraph 228 you state that  
15 this plan should have the following features, under  
16 point four. Since you mention additional charges here,  
17 what do you feel, what is your viewpoint with respect  
18 to a certain curb to be applied to charges?

19 DR. RIOUX: Well, we have given thought  
20 to this sir, but we rejected the idea, because we felt  
21 that it would encroach upon individual liberty, and it  
22 might be harmful to the good relationships which should  
23 exist between the physician and his patients.

24 We feel that we should reject this idea  
25 of a curb, but we do presume that the population, if  
26 it were covered by such an insurance plan, would take  
27 the necessary steps in order to avoid calling in the  
28 physician when it is not necessary. The medical  
29 profession which has always, and will always I hope,  
30 given service to the population, is not in favour of a  
curb in order to avoid an excessive number of visits,  
but we believe that the public should be educated in  
order to avoid calling in the physician uselessly.



aged people are overlooked in certain institutions where they should be accepted. There should be homes for them in the Province of Quebec. There are certainly such homes. I do not say that there are none, but we have the impression that they are not sufficient in number, and we hope that in the course of time in certain regions there will be small centres, small homes, which will receive aged people, who for various financial reasons cannot find acceptance elsewhere.

THE CHAIRMAN: I now refer to page

115. You mention here in paragraph 228 you state that this plan should have the following features, under point four. Since you mention additional charges here, what do you feel, what is your viewpoint with respect to a certain curb to be applied to charges?

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of a curb, but we do presume that the population, if it were covered by such an insurance plan, would take the necessary steps in order to avoid calling in the physician when it is not necessary. The medical profession which has always, and will always I hope, given service to the population, is not in favour of a curb in order to avoid an excessive number of visits, but we believe that the public should be educated in order to avoid calling in the physician unnecessarily.



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3 Furthermore, the citizens of this  
4 province may at some time consider themselves not very  
5 sick, and they may be called upon to pay additional  
6 charges for physicians' fees because they had a simple  
7 headache, so we want to spare them from this obligation  
8 of calling in a physician when they do not consider  
9 themselves to be seriously sick.

10 THE CHAIRMAN: Well, one last question.  
11 On page 123, in paragraph 253 it states here a majority  
12 of the Governors of the College are in favour of the  
13 optional plan?

14 DR. RIOUX: There are 12 Governors, Mr.  
15 Chairman, who voted for the optional plan, and seven,  
16 if I am not mistaken, who voted for the compulsory  
17 plan. There were two absentees. There is a total of  
18 21 in all.

19 THE CHAIRMAN: This minority, how is it  
20 possible to have a compulsory system without absolute  
21 State control?

22 DR. RIOUX: This is the very reason  
23 why 12 Governors voted for the optional plan.

24 THE CHAIRMAN: Well, is there anyone  
25 who wishes to speak for the minority?

26 DR. RIOUX: In this case I should not like  
27 to state a viewpoint, because there was no unanimity  
28 here. It would be easy to discuss this matter if there  
29 had been a unanimous vote in favour of either solution.

30 THE CHAIRMAN: Well, this applies to the  
entire country, the opinions are at variance.

DR. RIOUX: Well, those who voted for the







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4 compulsory plan sir, are opposed to the fact that part  
5 of the population would not be included in the plan.

6 THE CHAIRMAN: But the reasons are given  
7 in the brief?

8 DR. RIOUX: Yes.

9 THE CHAIRMAN: Well, I would like to  
10 ascertain, if possible, those who are in favour of the  
11 compulsory scheme. It states here that those who want  
12 a compulsory plan are still opposed to basic State  
13 control.

14 DR. RIOUX: Well, it states at the  
15 end of the brief that we do not want State control.

16 THE CHAIRMAN: Do all 19 Governors  
17 state that?

18 DR. RIOUX: No, 12 of them said it, but  
19 all of them were opposed to State control.

20 THE CHAIRMAN: Well, I simply ask you,  
21 is it possible to have a compulsory plan without State  
22 control?

23 DR. RIOUX: Well, we had in mind an  
24 autonomous, independent, administration sir. At this  
25 point we can say that it would be this administration  
26 which would oblige people to take out such insurance,  
27 and not the State, but this administration would  
28 represent not only the State, it would also represent  
29 the medical profession, it would represent the  
30 citizens, and it would represent also the insurance  
companies, so our principle would be that the State  
must not directly organize this plan, but it should be







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4 the administration of the plan which would maintain  
5 its own autonomy, and this administration would oblige  
6 the population to take out this insurance.

7 THE CHAIRMAN: A compulsory plan, or  
8 any plan, will you charge any premiums?

9 DR. RIOUX: Yes, it has been planned  
10 to charge premiums, but the administration, the  
11 independent administration, will decide on these premiums  
12 with the College of Physicians and Surgeons, which  
13 also establishes medical fees, rates for medical fees.

14 THE CHAIRMAN: Will there be any  
15 difference between those who are able to pay and those  
16 who are not able to pay to the Province? How will you  
17 distinguish between those who are unable to pay and those  
18 who are able to pay?

19 DR. RIOUX: In the Province of Quebec,  
20 at least in our province, 8% of the population which  
21 receives medical care is obliged to provide  
22 a certificate of indigence. In cases of needy mothers,  
23 cases of needy indigents the government makes no  
24 demand, but in the number of indigents, this covers 8%  
25 of the population which automatically would come under  
26 the new plan. We plan about an additional 15% of the  
27 population would apply -- would have to have this  
28 premium paid by the State. However, at the present time  
29 needy cases in hospitals with so-called public aid,  
30 this covers more than 8% of the population. I am  
speaking now of those who receive State assistance, that  
is cases like invalids or needy mothers or blind, et  
cetera who are outside of this scope, those who go  
to the hospital for care would be obliged to furnish





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4 proof of indigence. They must furnish a card testifying  
5 as to their economic status. The population up to now  
6 has never been against this requirement by the  
7 Provincial Government so under the plan the population  
8 would have to swear to the state of economic indigence.  
9 Since such a procedure has been done in the past we  
10 believe the same procedure must be followed in the  
11 future with respect to indigence, that is the requirement  
12 to furnish proof of indigence. At the beginning this  
13 proof would simply be made by oath, by taking oath.

14 THE CHAIRMAN: Thank you. Dr. Baltzan.

15 COMMISSIONER BALTZAN: Gentlemen, this  
16 morning we heard that doctors keep patients in the  
17 hospital on account of costly drugs which patients  
18 couldn't buy after they leave the hospital. My question  
19 in that connection is, is that prevalent? You are all  
20 practising physicians. I think I am free to ask you  
21 that question.

22 DR. WARD: I don't believe that that  
23 custom is prevalent in this province. There are ways  
24 in which drugs can be obtained. It certainly doesn't  
25 apply to surgical and obstetrical cases. It might  
26 be in cardiac cases or others which must have various  
27 drugs such as Digitalis and Diuretics for long periods.  
28 I don't believe it is a factor in prolonging hospital  
29 stays. On no service of mine, which is a medical  
30 service has the question ever arisen of keeping a person  
in, even a day longer because no drugs can be obtained.

31 COMMISSIONER BALTZAN: Thank you. My  
32 next question is, is it not true that the ability to  
33 obtain drugs are easier on the purse of the individual





proof of indigence. They must furnish a certificate, living  
 as to their economic status. The question is to how  
 has never been against this recommendation by the  
 Provincial Government so under the plan the provision  
 would have to refer to the state of economic indigence.  
 Since such a procedure has been done in the past we  
 believe the same procedure must be followed in the  
 future with respect to indigence, that is the requirement  
 to furnish proof of indigence. At the same time this  
 proof would simply be made by oath, by taking oath.  
 THE CHAIRMAN: Thank you, Dr. Ballman.

morning we heard that doctors keep patients in the  
 hospital on account of costly drugs which patients  
 couldn't pay for. They think the hospital is a question  
 in that connection as to what is the matter. You are all  
 practicing physicians. I think I am free to ask you  
 that question.

THE CHAIRMAN: I am a physician but that  
 custom is prevalent in this province. There are ways  
 in which drugs can be obtained. It certainly doesn't  
 apply to surgical and obstetrical cases. It might  
 be in certain cases on others which may have various  
 drugs such as opiates and narcotics for long periods.  
 I don't believe it is a factor in practicing hospital  
 stays. On no service of mine, which is a medical  
 service has the question ever arisen of keeping a person  
 in, even a day longer because no drugs can be obtained.  
 THE CHAIRMAN: I am sorry, I am not sure I  
 next question is, is it not true that the ability to  
 obtain drugs is a factor in the case of the individual?



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3 because of the relief from having to pay hospitalization?

4 In other words, it works in the opposite direction.

5 DR. WARD: May I just understand your  
6 question.

7 COMMISSIONER STRACHAN: Now that patients  
8 are relieved from having to pay hospitalization fees  
9 they are more able to pay for drugs?

10 DR. WARD: Yes, that is quite true.

11 COMMISSIONER BALTZAN: So that through  
12 the hospitalization methodology they are now in a  
13 better position to procure, to obtain drugs than before?

14 DR. WARD: That is true. The only  
15 people we would be speaking about here are the people  
16 who have absolutely no means at all and who under no  
17 circumstances can pay hospital bills or anything else.  
That is probably 8%.

18 COMMISSIONER BALTZAN: Have you some  
19 drugs that are given free, without charge, say these  
20 new drugs the anti-diabetics that are being used?

21 DR. WARD: Not to my knowledge.

22 COMMISSIONER BALTZAN: In some provinces  
23 such drugs are available.

24 DR. WARD: They are not available here.  
25 They can be obtained as our predecessor said this  
26 morning, I was present at their hearing, by various means  
of seeking charity and goodwill here or elsewhere.

27 COMMISSIONER BALTZAN: My next question:  
28 It was mentioned before, but I would like an enlargement  
29 in relation to doctors coming from outside of the  
30 Province, outside of the country. Have you a reciprocity



because of the fact that I want to pay for it  
I don't want to work in the same way  
DR. WARD: Yes, I understand you

question

COMMISSIONER BARTON: Now that patients  
are coming from having to pay for it  
they are more likely to pay for it

COMMISSIONER BARTON: So that through  
the organization method they are now in a  
better position to procure, to obtain drugs than before?  
DR. WARD: That is true. The only

people we want to exclude are the people  
who have absolutely no sense at all and who are so  
determined to pay no price at all for anything  
that is possibly of

COMMISSIONER BARTON: Have you some  
ways to take them free, without charge, say the  
new drugs, the substances that are being used?  
DR. WARD: That is my knowledge.

COMMISSIONER BARTON: In some instances  
such cases are possible

they can be only used as a reference  
nothing, I am afraid, to their health, but a person's means  
of seeking a remedy and the fact that a person  
COMMISSIONER BARTON: If that is all  
it was not the patient, but I am of the opinion  
in fact, it is the patient's fault, not the  
fact, I am afraid, of the fact that you are





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4 say with the U.S.A. graduates, United States graduates  
5 or must they still become Canadian citizens, pass your  
6 examinations in this province?

7 DR. WARD: No reciprocity with anybody  
8 at the College at all.

9 COMMISSIONER BALTZAN: Including the  
10 U.K.?

11 DR. WARD: No political jurisdiction  
12 anywhere in the world.

13 COMMISSIONER BALTZAN: May I proceed in  
14 my thinking to a certain anomaly. If you will agree  
15 with me it is an anomaly. My first premise, generally  
16 speaking, sickness is not on the increase in Canada.  
17 I am thinking we have excluded a number of epidemics.  
18 They have been avoided and it can be considered sickness  
19 in general is not on the increase. Let us accept that  
20 premise. On the other hand the question of medical  
21 health services are enlarging. If you agree to these  
22 two premises will you say that anomaly or incongruity  
23 is due in part, at least, to the fact measures of social  
24 health or social welfare deficiencies overflow and are  
25 included in the total health care scheme. Is my  
26 question clear?

27 DR. WARD: I see what you mean. In the  
28 first place I would agree with your premise that  
29 epidemic infectious disease is decreasing, but there is  
30 one other factor which I think is completely abolishing  
the condition we get from the absence or at least the  
diminution of infections and that is the fortunate or  
unfortunate fact that our population is aging rapidly and



say with the U.S.A. graduates, United States graduates  
or must they still become Canadian citizens, pass your  
examinations in this province?

DR. WARD: No reciprocity with anybody  
at the College at all.  
COMMISSIONER BARTON: Including the

DR. WARD: No political jurisdiction  
anywhere in the world.

COMMISSIONER BARTON: May I proceed in  
my thinking to a certain anomaly. If you will agree  
with me it is an anomaly. My first premise, generally  
speaking, sickness is not on the increase in Canada.  
I am thinking we have exhausted a number of remedies,  
they have been applied and it can be considered sickness  
in general is not on the increase. Let us accept that  
premise. On the other hand the question of medical  
health services are increasing. If you agree to these  
two premises will you say that anomaly or inconsistency  
is due in part, at least, to the vast masses of social  
health or social welfare departments overlaid and the  
included in the total health care scheme. Is my

DR. WARD: I see what you mean. In the  
first place I would agree with your premise that  
epidemic infectious disease is decreasing, but the is  
one other factor which I think is completely overlooked  
the condition we get from the spread of at least the  
disturbance of relations and that is the fortunate  
understand that the condition is a rapidly an



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4 there is becoming such a large number of us who are  
5 getting on in years. Those people not only are ill  
6 more, but they are ill with troubles which keep them  
7 under care for many, many months, and I believe that  
8 that has completely removed any edge which we have from  
9 the diminution of infectious disease. It is extra-  
ordinary the amount of care people over 60 require.

10 COMMISSIONER BALTZAN: It is very lucky  
11 for you and I that that is the case.

12 THE CHAIRMAN: Add a couple more of us.

13 COMMISSIONER BALTZAN: We find in other  
14 areas where these two elements, actually, medical  
15 diagnosing and therapeutics is one portion of the  
16 question and inadequacies in social welfare, living  
17 standards contributes to the health picture, and if  
18 one were taken care of the other would be lessened,  
for example, better food.

19 DR. WARD: Better food, even freedom  
20 from anxieties, I think, would probably reduce the  
21 amount of medical care necessary for a large number of  
people.

22 COMMISSIONER BALTZAN: Even having to  
23 ask questions as now. You were speaking about the  
24 general practitioner and the specialist. Definitely the  
25 medical profession has tended to support, and medical  
26 schools have tended to prepare doctors who enter general  
27 practice. We have had before us a number of doctors  
28 which emphasizes that there is still an insufficient  
29 number of certain specialties to units of population.  
30 We have heard that from the pediatricians, neurologists,







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3 the anaethetists, et cetera, et cetera, so that it  
4 isn't a question, or is it, that specialization is  
5 overriding the general practitioners' domain and because  
6 of the need of specialists fewer men go into general  
7 practice. Do you think it is because too many go into  
8 specialty training that you have fewer general  
9 practitioners when there is, as we have heard from these  
10 organizations a demand for even more specialists in  
11 their field?

12 DR. WARD: Dr. Bonin, would you care  
13 to answer that.

14 DR. BONIN: Well, sir, it is true that  
15 the graduate students are inclined more and more to take  
16 up specialization, but a report of the American Medical  
17 Association states in 1955 63% of all graduates under-  
18 took specialization and 33% chose general practice. In  
19 1961 there are 78% graduates that have specialized and  
20 the rest undertook general practice. There was a  
21 remainder of 4% who took up research. That is a fact,  
22 sir, this trend is becoming more and more accentuated.

23 COMMISSIONER BALTZAN: You have then  
24 really a division of your specialists, at least, in two  
25 main branches, those that give health service attention,  
26 and those that go into scientific pursuits such as  
27 research.

28 DR. BONIN: About 4% in research. That  
29 figure doesn't change.

30 COMMISSIONER BALTZAN: May I ask you  
this, you in Quebec have your own specialty boards?

DR. WARD: We have.







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4 COMMISSIONER BALTZAN: How long have  
they existed?

5 DR. WARD: Since 1948, actually. We  
6 granted specialists before on the basis of the holding  
7 of the F.R.C.P. or the Royal College Specialist's  
8 Certificates or by the corresponding British qualifica-  
9 tion or the possession of the Fellowship of the American  
10 College of Physicians and Surgeons or the D.B.S. or one  
11 of those. We started our own examinations in 1955. That  
12 was the cut-off date. We still passed -- I think I  
13 am right, Dr. Rioux, in 1948. I think that was the  
first.

14 DR. RIOUX: The last was granted in  
15 1948. We started having our own examination after 1955.

16 THE CHAIRMAN: Irrespective of holding  
17 these other qualifications?

18 DR. WARD: It is written in the law  
19 we shall not be influenced by the possession of any  
20 other qualifications, nothing but the Provincial  
qualifications should be the hallmark of the specialist.

21 COMMISSIONER BALTZAN: May it be known  
22 why that step was taken?

23 DR. WARD: In Quebec we like provincial  
24 autonomy. We are provincia' autonomists and it is an  
25 expression of that desire for provincia' autonomy.

26 COMMISSIONER BALTZAN: Thank you very  
27 much. There are just one or two other things and I am  
28 finished. You were speaking of the great shortage of  
29 beds, the lowest in Canada in the Province of Quebec.  
30 You may be able to answer this, what are your chances now





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4 under the new Quebec Hospital Commission Scheme to  
5 obtain that increase versus the old traditional thing  
6 of making public appeals in communities to build  
7 hospitals, or in cities. We have a very good example  
8 of that in Montreal.

9 DR. RIOUX: As we already stated, sir,  
10 we suggest and advocate that there should be, in order  
11 to furnish sufficient beds in the general hospitals,  
12 we suggest the chronic patients should be admitted to  
13 special hospitals for them. We suggest especially that  
14 convalescent patients who remain for three or four days  
15 and which could be treated outside the hospital should  
16 leave the general hospital and this will effect a  
17 greater number of beds. As stated there is a lack of  
18 11,000 beds in the province. How can we increase the  
19 number of available bed space -- well, if our plan for  
20 health insurance, and we advocate this on an autonomous  
21 basis, we feel construction of new hospitals and  
22 significant increase of bed space be insured by the  
23 Provincial Government. This applies particularly with  
24 respect to mental hospitals. It would be for the  
25 Provincial Government to construct these new hospitals.  
26 We believe it is the Provincial Government and not the  
27 public charities which should undertake this. If the  
28 Provincial Government were authorized to administer this  
29 insurance plan as we suggest, there will be a sufficient  
30 bed space available in the hospitals.

31 COMMISSIONER BALTZAN: May I ask you,  
32 sir, what do you think of your chances of doing business  
33 with the governments who have to provide that money,  
34 because there have been experiences in other provinces



under the new Quebec Hospital Commission? How can  
obtain that increase versus the old transitional stage

of making public hospitals in community care to 1971  
hospitals, or in other. We have a very good example  
of this in Montreal.

MR. RICHIE: As we already stated, sir,  
we all want and advocate that there should be, in order  
to furnish and patient beds in the general hospital,  
we suggest the chronic patients should be admitted to  
special hospitals for them. We suggest especially the  
convalescent patients who remain for three or four days  
and would not be treated outside the hospital should

leave the general hospital and this will effect a  
greater number of beds. As stated there is a lack of  
11,000 beds in the province. How can we increase the  
number of available bed space -- well, if our plan for  
health resources, and we advocate this on an autonomous

basis, we feel construction of new hospitals and  
significant increase of bed space be insured by the  
provincial Government. This approach particularly with  
respect to mental hospitals. It would be for the

provincial Government to construct these new hospitals.  
In believe it is the Provincial Government and not the  
local authorities which should undertake this. If the  
provincial Government were authorized to administer this  
increase plan as we suggest, there will be a sufficient  
bed space available in the hospitals.

COMMISSIONER RICHIE: May I ask you,

sir, what do you think of your chances of doing this  
with the government who have to provide that money,  
because there have been experiences in other provinces



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3 of such demands upon governments who have charge of  
4 this and they were rather difficult people to do  
5 business with.

6 DR. RIOUX: Well, sir, in our brief  
7 we stated the money which we think, since we plan to  
8 give obligatory service to all the population, if the  
9 plan were operated we believe that this would be the  
10 duty for the Provincial Government to give the service  
11 to the population and we foresee that the Government,  
12 the Provincial Government would be in charge of the  
13 construction of new hospitals and to thus furnish  
14 additional bed space and would also give assistance to  
15 patients who would require it. As we already stated  
16 the Provincial Government has sufficient funds to do  
17 this. Furthermore, if part of the money required could  
18 be furnished as was stated in this morning's newspapers  
19 -- could be furnished to the extent that would satisfy  
20 the great needs that we indicated, particularly in this  
21 area, we recognize all this should be done on a  
22 provincial basis since it is the province's right and  
23 duty to fulfil this obligation. We must observe that  
24 the Provincial Government must fulfil this duty. Does  
25 that answer your question?

26 COMMISSIONER BALTZAN: Yes. I can  
27 pursue it a little further and ask a lot more questions,  
28 but my colleagues understand these things and will help  
29 me out.

30 COMMISSIONER VAN WART: I want to make  
one observation. It is nice that brief number 222 has  
been assigned to the medical group. That is all, sir.







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THE CHAIRMAN: Miss Girard?

COMMISSIONER GIRARD: Mr. Chairman,  
Dr. Rioux, in your statement at the beginning of your  
submission you referred to a point which is an expedient  
which doesn't seem to place any of the parties concerned  
-- I am referring to the colonies, this displeases the  
medical profession. It also displeases the nurses, or  
at least, all the nurses' professional associations who  
sees the nurses placed in situations in which they are  
more or less compelled to practise medicine.

And now, since we have the same  
viewpoint more or less on this problem you have suggested  
a solution may be in giving additional salaries to  
doctors in order to furnish incentive to draw them to  
these places. However, since this solution concerns  
the future and since this situation exists for many  
years, could you not tell us what could be done in the  
immediate future? I should like to tell you something  
that struck my attention during our trip and I should  
like to have your reaction to this. We know that our  
nurses must be mid-wifery trained for this. We do not  
train them to be mid-wives in our nursing schools. In  
the Province of Alberta, for instance, the nurses who  
went to work in these colonies were required to do things  
for which they had not been trained with, of course,  
the consent of a physician because the physician was  
unable to attend personally. And now, these nurses should  
at least be trained for these tasks and these nurses  
received at State expense a certain training for mid-  
wifery; the course is given to these nurses similar to the





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4 first year of the mid-wifery course as given in the  
5 United Kingdom. We know the English mid-wives have an  
6 excellent record with respect to infant and mother  
7 mortality. They do excellent work and they do this  
8 work with the consent of the profession. What is your  
9 reaction to this?

10 DR. RIOUX: Well, if you will allow me,  
11 firstly, we should not accept as a conclusion that  
12 doctors do not want to go to these colonies because  
13 several physicians have gone to practise medicine in  
14 the colonies but they were unable to live there and  
15 I do not think you can attribute to that such a thing  
16 that they would be ready to leave their families. There  
17 have been physicians who lived for four or five years  
18 but they have been forced to return because they were  
19 unable to keep their families on the income given to  
20 them. There are some who have gone to the colonies,  
21 there are some at the present time who have gone but  
22 they cannot remain there for any length of time which  
23 is quite understandable. There is in our College a  
24 committee for mid-wifery and this committee has already  
25 issued mid-wife certificates and we intend to issue  
26 such certificates if there is need for them.

27 We should like to have the candidates  
28 pass certain examinations or, if need be, they can give  
29 service to the population if a physician is not  
30 available. We have provided for such things since there  
is a committee in our College covering mid-wifery.  
Some four or five years ago mid-wife certificates were  
issued but nurses who do not wish to exercise the





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first year of the mid-wifery course as given in the United Kingdom. We know the English mid-wives have an excellent record with respect to infant and mother mortality. They do excellent work and they do this work with the consent of the profession. What is your reaction to this?

DR. R100X: Well, if you will allow me,

firstly, we should not accept as a conclusion that doctors do not want to go to these colonies because several physicians have gone to practise medicine in the colonies but they were unable to live there and I do not think you can attribute to that such a thing that they would be ready to leave their families. There have been physicians who lived for four or five years but they have been forced to return because they were unable to keep their families on the income given to them. There are some who have gone to the colonies, there are some at the present time who have gone but they cannot remain there for any length of time which is quite understandable. There is in our College a committee for mid-wifery and this committee has already issued mid-wife certificates and we intend to issue such certificates if there is need for them.

We should like to have the candidates pass certain examinations or, if need be, they can give service to the population if a physician is not available. We have provided for such things since there is a committee in our College covering mid-wifery. Some four or five years ago mid-wife certificates were



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4 profession in their own country go abroad so we can  
5 issue them if there is need.

6 COMMISSIONER GIRARD: Well, I am not  
7 trying to encourage or to promote mid-wifery. You must  
8 bear in mind that I did not feel that the physicians  
9 were not unwilling to go there but let us examine the  
10 situation as it stands; nurses go to the colonies and  
11 are forced to do something which they should not do.  
12 The nursing profession is accused of practising medicine.  
13 We do not want to do this. However, these nurses are  
14 alone, they object to doing this but they are forced  
15 into it. In the face of this situation could not your  
16 college or any association make representations to the  
17 Minister of Health, for instance, to make sure that  
18 these nurses who go to these colonies should be required  
19 to take this course? I do not want it to be a general  
20 practice, I do not want all our nurses becoming mid-  
21 wives. The nurses of the Province of Quebec would not  
22 do this, they do not want to do this but since the  
23 nurses are placed in the situation where they are  
24 obliged to do things which are outside their scope,  
25 would it not be better to ensure a situation where such  
26 nurses would be trained to carry out these tasks before  
27 they went to these places. When the physician arrives  
28 then in one of these remote places then the nurse would  
29 no longer be authorized to carry out such work but at  
30 least she should be given training to do such work.  
We know she is given three months obstetrical training  
but it is inadequate for her to carry out the physician's  
role in these remote places.







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3 DR. RIOUX: Well, in order to be  
4 consistent if you are thinking of the organization of  
5 the health plan in the province, it is, of course,  
6 understood that all the citizens of the province should  
7 be able to benefit from medical care; all citizens of  
8 the province wherever they reside are entitled to  
9 require the same services as those who live elsewhere.  
10 In this case the Provincial Government should take such  
11 steps to enable physicians to go to these places and  
12 to live there. Now, if you are thinking of the services  
13 that should be given to the population if such plan were  
14 implemented, we must take steps in order to ensure it  
15 is possible for these nurses to go to these places to  
16 work. I reiterate, it would seem to be only logical  
17 that if we are to have a health insurance, all citizens  
18 in the province are entitled to the same medical care  
19 wherever they live so the provincial government should  
20 take steps in order to ensure care to all members of  
21 the population and to supply all regions of the  
22 province with physicians. This is a logical conclusion  
23 because people receive medical care from a physician  
24 and do not wish to pay for it then the State must pay  
25 his fees. I believe this matter concerns our presence  
26 here until such a plan is adopted I have no objection  
27 to having those people who care for the sick people  
28 should be able to go to the colonies with as much  
29 knowledge as possible because they would have to do all  
30 sorts of tasks.

COMMISSIONER GIRARD: Thank you.

THE CHAIRMAN: I think we will now





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recess until two o'clock.

---Luncheon recess.

---On resuming at 2:00 p.m.

THE CHAIRMAN: If we may now come to order we will proceed. Dr. Rioux.

DR. RIOUX: Mr. Chairman, I hope you will excuse us for not having submitted our morning's brief earlier. You know that the medical profession has asked us to change certain opinions we have given. I should like to furnish you some figures we were unable to give you this morning.

Convalescent hospitals do exist in Montreal. There is the Montreal Convalescent Hospital, of 100 beds. There is the Julius Richardson Hospital, with 100 beds. There is another with also 100 bed capacity. In Quebec, which is my own city, there is only one convalescent hospital, a small one with only 15 beds. So I reiterate that it is essential for every general hospital to have a particular section for convalescent cases.

THE CHAIRMAN: Do you think that each hospital should have a section for mental illnesses?

DR. RIOUX: Well, in this area a great improvement has been attained, because all our general hospitals do have beds for certain psychiatric illnesses. This of course facilitates the services, and it also brings into the hospital certain patients who would not







Rioux

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3 reach the hospitals if there were no such sections  
4 available.

5 All our general hospitals, I repeat,  
6 do have psychiatric services, and do have beds  
7 available for patients who require care for psychiatric  
8 illnesses, this in addition to the specialized cases.

9 THE CHAIRMAN: Do you feel that mental  
10 hospitals will disappear?

11 DR. RIOUX: Well, sir, the government  
12 of the Province of Quebec has appointed a Commission  
13 which has made its report a few days ago, and it  
14 conducted an enquiry into this very matter. I cannot  
15 answer your question, because I personally haven't  
16 read the brief. The matter is presently under  
17 deliberation. I don't want to prejudge this enquiry.  
18 The matter has not yet been settled, but I know a brief  
19 has been submitted and the conclusions of this brief  
do refer to this very matter you have raised.

20 COMMISSIONER FIRESTONE: Mr. Chairman,  
21 I would like to address my first question to Dr. Ward,  
22 following an answer which Dr. Ward gave to a question  
23 asked earlier today about the matter of drug distribution  
in hospitals.

24 Do I understand you correctly, Dr. Ward,  
25 when you state that you had no knowledge of any extension  
26 of hospital stay because drugs were not available to  
27 be given to an indigent patient? Do I understand that  
28 this reply was based on your experience in your own  
hospital, that is the Montreal General?

29 DR. WARD: That is so Mr. Firestone. I  
30







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3 have been an internist in the Montreal General Hospital  
4 for many, many years and this question only arises in  
5 the last two years, when we have had hospitalization  
6 insurance, and to my knowledge this question has never  
7 arisen, nor has anyone foreseen it, because at committee  
8 meetings, which are being held all the time to make  
9 sure we make the best use of our beds, and that people  
10 get out of the hospital as soon as possible, that  
11 question has never been raised.

12 COMMISSIONER FIRESTONE: That is based  
13 on your experience in your own hospital, and it does  
14 not refute the possibility, as was suggested to us by  
15 other doctors, that such a practice exists in other  
16 hospitals?

17 DR. WARD: I suppose that probably if  
18 such a problem existed it would have possibly been brought  
19 to the knowledge of the College of Physicians, of which  
20 I have been the President for most of the time that we  
21 have had the new hospitalization insurance act, and I  
22 think if it exists in any aggravated form it would  
23 certainly have been brought to our attention.

24 COMMISSIONER FIRESTONE: Well, perhaps  
25 there are good reasons for not bringing it to your  
26 attention, because if this matter were brought to your  
27 attention, and to the attention of the government,  
28 action might be taken to deal with this situation, so  
29 there might be good reasons for not bringing it to your  
30 attention.

31 You were referring to other reasons which  
32 might contribute to the extension of a hospital stay

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might contribute to the extension of a hospital system



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3 beyond which good medical practice and judgment would  
4 require. Can you, on the basis of your own experience  
5 in your own hospital, give us some reasons that would  
6 contribute to such an extension of stay?

7 DR. WARD: One is a particularly sad  
8 reason, and that is the disinclination of a certain  
9 number of people to have their elderly charges returned  
10 home, where they create a certain amount of extra  
11 housekeeping and nursing care. The desire on the part  
12 of patients themselves, notably women with large  
13 families, to give themselves an extra day or two of  
14 convalescence. Much could be said that they were  
15 justified in this perhaps. They had need of rest.  
16 They feel they would like to have rest and quiet and  
17 peace for another three days before they undertake all  
18 their duties, and to many, particularly the wife of  
19 the family, a home isn't a place of rest.

20 COMMISSIONER FIRESTONE: If there were  
21 a home care service in existence on a rather comprehensive,  
22 substantial basis, providing the patient with certain  
23 facilities at the home, would that not be a way of  
24 reducing the stay in the hospitals in cases where the  
25 medical opinion said it was no longer required?

26 DR. WARD: It certainly would. There  
27 would be two classes of things. One for the reasons I  
28 have mentioned, one would be nursing service for elderly  
29 people, and those with chronic illnesses, and the other  
30 would be a sort of visiting baby care, or care of a  
house, really a visiting maid, that would give the  
mother of the family some chance to get rest and finish







Rioux

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her convalescence.

COMMISSIONER FIRESTONE: If such a scheme were brought into operation, would that not reduce the number of stays that hospital beds would be in use for patients, and thus free hospital beds for people urgently in need of the beds, and thus reduce the waiting list, which we are told is quite long in the Province of Quebec?

DR. WARD: I agree wholeheartedly.

COMMISSIONER FIRESTONE: Would you say that your College would be in favour of the establishment of such a programme?

DR. WARD: Home nursing care, I would say so, yes.

COMMISSIONER FIRESTONE: Thank you very much Dr. Ward. If I may now turn to a broader question, the question of the medical care insurance proposal which has been put to this Commission in your brief, and Dr. Bonin, I will be addressing these questions to you, but please feel free to call on your colleagues to deal with any aspects you wish.

May I first of all congratulate you and your associates on the very competent brief which you have submitted. It is well documented, and it provides us with sufficient detail to form an opinion as to what you have in mind, and by being specific you have been particularly helpful to us, and we want to thank you for the hard work you have done, and those associated with you.

Now sir, it would help us in understanding



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Now, it would be in my mind to





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3 the plan if I were to get some explanation of some  
4 features of the plan that is acceptable to you.

5 Do you propose a provincial medical  
6 care insurance plan which would provide comprehensive  
7 medical care for the people of the Province of Quebec?

8 DR. BONIN: Certainly.

9 COMMISSIONER FIRESTONE: Would your  
10 definition, sir, of comprehensive medical care include  
11 services of the general practitioner?

12 DR. BONIN: Certainly.

13 COMMISSIONER FIRESTONE: Would it include  
14 the services of a surgeon?

15 DR. BONIN: Certainly.

16 COMMISSIONER FIRESTONE: Would it include  
17 preventive medicine?

18 DR. BONIN: Certainly.

19 COMMISSIONER FIRESTONE: Would it include  
20 physical and mental health?

21 DR. BONIN: Certainly.

22 COMMISSIONER FIRESTONE: And would mental  
23 health cover both the visit to the general practitioner  
24 and the specialist?

25 DR. BONIN: Certainly.

26 COMMISSIONER FIRESTONE: Thank you.  
27 In other words, you are in favour of a comprehensive  
28 medical care plan which will leave nothing uncovered?

29 DR. BONIN: Yes, including mental  
30 patients.

COMMISSIONER FIRESTONE: Thank you very  
much. Now, is this plan which you propose a profit  
plan or a non-profit plan?



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Rioux

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4 DR. BONIN: Perhaps you should ask an  
5 economist. I imagine it is a non-profit plan.

6 COMMISSIONER FIRESTONE: Forgive me  
7 if I address you as doctors with some questions which  
8 have some economic and financial implications, but you  
9 will appreciate that if a plan is to be introduced we  
10 have to examine not only the medical features, but also  
11 the manner in which it will work and the manner it will  
12 be paid for. Am I permitted to ask questions along  
13 this line?

14 DR. BONIN: I am prepared to answer you  
15 to the best of my ability.

16 COMMISSIONER FIRESTONE: That is good  
17 enough for us sir. You say this is a non-profit plan,  
18 administered by a Commission which you have suggested  
19 would comprise representatives of the medical profession,  
20 insurance companies, mutual companies as you call them,  
21 and the Provincial Government. Now sir, if the plan  
22 includes insurance companies, are you referring to  
23 commercial carriers, that is insurance companies that carry  
24 insurance policies?

25 DR. BONIN: Well, as I see it all  
26 companies, all insurance companies could participate.

27 COMMISSIONER FIRESTONE: Well, that will  
28 include what is called commercial insurance companies?

29 DR. BONIN: I imagine so.

30 COMMISSIONER FIRESTONE: Well now sir,  
I take it these commercial insurance companies operate  
on a profit basis. How do you reconcile then your  
proposal that you are proposing a non-profit plan?



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Bonin

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4 DR. BONIN: Since we are asking for only  
5 a single fee, that should be the lowest possible price,  
6 it should be the same price for all the insurance  
7 companies participating.

8 COMMISSIONER FIRESTONE: Well, would  
9 you then expect that commercial insurance companies  
10 would not participate on a profit basis, but on a non-  
11 profit basis?

12 DR. RIOUX: We have the impression, sir,  
13 that we would prefer a non-profit insurance company.

PB/hm 14 COMMISSIONER FIRESTONE: Therefore, your  
15 proposal is really similar to non-profit doctors  
16 sponsored insurance plans as exist in some other  
17 provinces. Is that what you have in mind?

18 DR. RIOUX: That is because these  
19 companies already exist in the province and they are  
20 doing wonderful work, not only for themselves, but  
21 also for the citizens that they protect.

22 COMMISSIONER FIRESTONE: Are you referring  
23 to mutual, non-profit medical sponsored plans such as  
24 the Service de Sante de Quebec?

25 DR. RIOUX: That is correct.

26 COMMISSIONER FIRESTONE: That is what  
27 you have in mind?

28 DR. RIOUX: Yes sir.

29 COMMISSIONER FIRESTONE: You don't  
30 include commercial insurance companies that will insure  
in the market in order to make a profit?

THE CHAIRMAN: He said they also  
include them .







Rioux

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4 COMMISSIONER FIRESTONE: I would like  
5 to have your views.

6 THE CHAIRMAN: He has already said  
7 that once.

8 COMMISSIONER FIRESTONE: We would like  
9 to have an explanation between profit and non-profit.  
10 That is what I mean.

11 DR. RIOUX: We would prefer that these  
12 companies be non-profit companies or if they are  
13 companies in the business for profit, at least, they  
14 should have premiums which would be the same, at the  
15 same rate as the non-profit companies, because if  
16 profit making companies were to participate their  
17 premiums will be higher than in the case of non-profit  
18 insurance companies.

19 COMMISSIONER FIRESTONE: If I understand  
20 you correctly you are therefore in favour, in general  
21 of a plan which would be both a non-profit and profit  
22 plan, but you would have the same premiums payable by  
23 all companies, you would combine both features, profit  
24 and non-profit, but have the same premium payable?

25 DR. RIOUX: That is right, and as low  
26 as possible.

27 DR. WARD: May I say a word, the margin  
28 of profit is very small in this type of business in  
29 even an profit plan, and actually, I wouldn't foresee  
30 there would be much difference between what we call  
resources in Blue Cross and Service de Sante Quebec and  
what are the resources which are provided by the profit





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4 companies. Really there is such a tiny proportion of  
5 the premium actually going into profit in the mutual  
6 companies. I would think the so-called profit companies  
7 might very well be used, and used to a great degree.

8 COMMISSIONER FIRESTONE: There are no  
9 objections in principle, whether profit or non-profit,  
10 the main thing is, as we understand what you have in  
11 mind is a non-profit organization, or organizations  
12 that combines both non-profit and profit companies and  
13 associations, that is really the concept that you have  
14 in mind.

15 DR. RIOUX: With minimum premiums.

16 COMMISSIONER FIRESTONE: With minimum  
17 premiums. Now, sir, how would that minimum premium  
18 be established?

19 DR. RIOUX: Well, the administration  
20 could establish the premium, of course, upon the advice  
21 of economists and perhaps with the assistance of  
22 advice from the medical profession, because the medical  
23 profession has a word to say in this matter since its  
24 fee must be taken into account, and therefore the  
25 medical association must be consulted on this matter.

26 COMMISSIONER FIRESTONE: Therefore you  
27 would proceed on this basis, you would have a consulta-  
28 tion with the medical profession to establish the  
29 schedule of fees, and then you would have actuarial  
30 calculations what the cost of such premium might be  
for the province on a whole and the premium would be  
established on that basis.

DR. RIOUX: By the administration.





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mind is a non-profit organization, an association  
that combines both non-profit and profit companies and  
associations, that is really the concept that you have  
in mind.

COMMISSIONER FIRSTONE: With mutual  
premiums. Now, sir, how would that mutual premium  
be established?  
DR. BROWN: Well, the administration  
could establish the premium, of course, upon the advice  
of actuaries and together with the assistance of  
advice from the medical profession, because the medical  
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established on that basis.  
DR. BROWN: By the administration.



Rioux

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THE CHAIRMAN: The first premium?

DR. RIOUX: The first premium.

THE CHAIRMAN: Experience would determine it?

DR. RIOUX: Yes. Well, the premium could change every year. It depends on the number of participants in the plan.

COMMISSIONER FIRESTONE: Now, sir, you would then have a premium, would this be the same premium for everybody in the Province irrespective of age, condition, occupation, et cetera.

DR. RIOUX: Well, otherwise it would be difficult to administer such a plan if the premiums weren't standard.

COMMISSIONER FIRESTONE: These premiums would then cover the payment of those that could afford the premium and make a contribution to the plan.

DR. RIOUX: Yes sir.

COMMISSIONER FIRESTONE: There are two other groups which may find difficulty paying the premium. One is what we call the indigent people that are in the welfare category, and which are fairly easily established because they are already in that category, and secondly, what is sometimes called the medical indigents. These are people that are not in the welfare category but which for economic reasons, reasons of large families or because they have lost their job are unable to pay the premiums. Who would pay the premiums for both the indigents and the medical indigents? You said, if I understood you correctly 8% were indigent and 15% were in the group I have described as medical







Rioux

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3 indigents. If my understanding wasn't correct, please  
4 correct me.

5 DR. RIOUX: Sir, obviously, the medical  
6 profession has always been concerned for the needy,  
7 and it would certainly agree that the needy cases should  
8 be included in the plan, especially those needy cases  
9 which require this type of protection, and those who are  
10 not in a position to pay premiums, well, the Province  
11 should pay the premium in any particular form. We  
12 have also suggested those who are less strong  
13 economically, that is those who have many children in  
14 the family should receive some assistance by the  
15 administration.

16 COMMISSIONER FIRESTONE: If such a  
17 plan were to come into operation how would the fees of  
18 the doctor be paid, say the patient has seen the doctor,  
19 would the doctor who is then ready to send his bill,  
20 would he send his bill to the Commission or to the  
21 patient?

22 DR. RIOUX: I believe that in order  
23 to safeguard the present existing harmony between doctor  
24 and patient, we have the impression that the patient  
25 should continue to pay his physician so that medical  
26 services, so that medical services should remain  
27 personal, so that there should be a better contact  
28 between the patient and doctor, rather than the cheque  
29 being sent directly by the administration. However, in  
30 order to avoid any friction or conflict between the  
patient and the doctor we would prefer that the patient  
pays his doctor personally.





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4 THE CHAIRMAN: It doesn't say this in  
5 your brief, sir, it states that you prefer a plan of  
6 service.

7 DR. RIOUX: Well, the service plan is  
8 in line with the required needs. Well, perhaps I may  
9 be mistaken, but we would prefer that the cheque be paid  
10 by the patient rather than the administration, but this  
11 changes nothing in the service plan. Under the service  
12 plan it means that we will not charge additional fees.  
13 In any case the fees must be paid by someone. Under the  
14 service plan, it doesn't require payment of additional  
15 fees, however we prefer that the patient should pay  
16 our fees and the patient be reimbursed by the  
17 administration. We prefer this because the patient,  
18 physician contact would be much better.

19 THE CHAIRMAN: What contact do you mean?

20 DR. RIOUX: This contact is a sacred  
21 element.

22 THE CHAIRMAN: What difference is there  
23 if I take the cheque and give it to the administration?

24 DR. RIOUX: This is something we prefer  
25 from the financial point of view, that the administration  
26 pay because there might be some abuses, such things  
27 do occur, particularly with respect to insurance  
28 companies. Sometimes the patient refuses to pay the  
29 doctor or pays him only half the required fee, but  
30 nevertheless we have the impression that this contact  
with the patient, even in the field of payment it is  
better is the patient himself pays the bills.

COMMISSIONER FIRESTONE: If I might pursue...







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4 THE CHAIRMAN: I am not trying to  
5 convince you to the contrary. I am not trying to change  
6 your views, but you understand the importance of this  
7 point.

8 DR. RIOUX: Sir, we have so many reasons  
9 to feel that the relationship between the patient and  
10 the physician are not as harmonious as would be  
11 desired in all cases, and we should like to avoid all  
12 causes of friction. This is one thing we have observed  
13 in many briefs that have been submitted, statements  
14 unfavourable to the medical profession. We should like  
15 to make some attempts to improve the relationship  
16 between the physician and patient. This is one way.

17 COMMISSIONER FIRESTONE: If I may  
18 pursue this point to see how it would work in practice.  
19 Is it your recommendation that the doctor will bill  
20 the patient and the patient will send in the bill to  
21 the Commission and the Commission will then send the  
22 cheque to the patient and the patient will then send  
23 the cheque to the doctor. Is that what you recommend?

24 DR. RIOUX: From the administration  
25 standpoint, sir, this may involve certain complications,  
26 but we must maintain the position that I have just  
27 explained to you with respect to this matter in order  
28 to avoid any conflict and in order to safeguard the  
29 liberty of the public to pay the doctor.

30 COMMISSIONER FIRESTONE: ~~What~~ I am  
concerned with is trying to understand what you  
recommend, for whatever reasons you make the  
recommendation, therefore I understand this is your



THE CHAIRMAN: I am not trying to convince you to the contrary. I am not trying to change your views, but you understand the importance of this point.

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COMMISSIONER FLETCHER: If I may pursue this point to see how it would work in practice, is it your recommendation that the doctor will bill the patient and the patient will send in the bill to the Commission and the Commission will then send the cheque to the patient and the patient will then send the cheque to the doctor. Is that what you recommend?

DR. RIOUX: From the administration standpoint, sir, this may involve certain complications, but we must maintain the position that I have just explained to you with respect to this matter in order to avoid any conflict and in order to safeguard the liberty of the public to pay the doctor.

COMMISSIONER FLETCHER: What I am concerned with is trying to understand what you recommend, for whatever reasons you make the recommendation, therefore I understand this is your





Rioux

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3 recommendation in the interest of maintaining patient,  
4 doctor relationships. Now, sir, when the Commission  
5 sends the cheque to the patient is the cheque made out  
6 in the name of the patient or in the name of the doctor?

7 DR. RIOUX: Many insurance companies  
8 send the cheque directly to the patient. We have the  
9 impression that in certain cases, we have the impression  
10 the cheque is made out to the patient and sometimes to  
11 the doctor. We prefer that the cheque should be  
12 made out to the patient. The cheque should be made  
13 out to the patient and the patient should make payment  
14 to the doctor.

15 THE CHAIRMAN: Well, he may take this  
16 cheque and buy shoes.

17 DR. RIOUX: Well, this is the responsi-  
18 bility of the patient, sir. We hope that under such a  
19 plan the doctor will maintain his own liberty and we  
20 presume that the patient must still maintain his own  
21 liberty. This liberty should be protected.

22 COMMISSIONER FIRESTONE: You will recall,  
23 sir, the whole purpose of the insurance scheme is  
24 A - to provide for the payment of the medical care  
25 services rendered by the doctor and the patient being  
26 covered against the risks of illnesses, but on the  
27 basis of your suggestion, all you make sure is that the  
28 patient has the money, there is no assurance that the  
29 doctor gets the money and therefore the medical  
30 profession, under your plan would still have the  
collection problem that you have at the present time,  
because if the patient, as the Chairman says, cashes the





Rioux

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3 cheque and doesn't pay the doctor, the doctor will still  
4 have a collection problem. He wouldn't have the  
5 collection problem if the cheque were made out to him  
6 and sent to him. Are you not interested that the  
7 doctor should be paid for his services?

8 DR. RIOUX: I believe we are ready to  
9 make this sacrifice, sir, in order to maintain this  
10 contact with our patients. Actually there would be  
11 some loss involved in such a health plan, and we would  
12 prefer that the cheque be sent to us directly. However,

13 speaking on behalf of the profession, we would agree  
14 that the patient pay us, and we would be ready to  
15 accept the cost of collection for difficult cases, but  
16 here again, we feel that the population will be grateful,  
17 at least I hope they will be grateful for the plan  
18 we have proposed and we hope that they will pay.

19 COMMISSIONER FIRESTONE: The cost of  
20 collection, the cost of administration on the basis  
21 which you have suggested would be considerably higher than  
22 if the Commission would pay, make payment directly to  
23 the physician, and therefore the end result would be  
24 that higher premiums will have to be collected to pay  
25 for such extra costs which are not required in the  
26 interests of an efficient system. Are you therefore  
27 recommending an inefficient system in order to maintain  
28 the relationship which will have the effect of a higher  
29 payment by the patient in order to give the doctor  
30 his fees which he is entitled to, and secondly a higher  
payment by the Government for the indigent, which, in  
turn, will mean higher taxes. Therefore, are you in







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4 favour of A, an inefficient system that will cost more  
5 to the patient, cost more to the government, cost more  
6 to the taxpayers just to retain the relationship of  
7 doctor-patient relations. Is that your view?

8 DR. RIOUX: I have the impression that  
9 if we want to agree the patient should pay us, well,  
10 we ourselves should decide on collection costs. I  
11 don't believe that the premium would be increased by  
12 the fact that the patient himself must pay. I believe  
13 that the medical profession in requiring the maintenance  
14 of this harmonious contact with its patients will also  
15 accept the responsibility of paying the collection  
16 costs, and I don't believe the government will be  
17 obligated to charge this higher premium to cover  
18 collection costs. I reiterate that I have the impression  
19 that the public which will benefit from such services  
20 at this time -I believe the public in Quebec will be  
21 careful, will take account of this and will be ready  
22 to pay the doctors, even of the doctor who gives many  
23 services without causing any additional charges. I  
24 believe this will be so.

25 COMMISSIONER FIRESTONE: Now, sir, you  
26 realize that a more complicated administrative system  
27 will cost more money, that money has to be paid by  
28 someone. You either raise the premium or you pay less  
29 to the doctor. It must come from one of the two  
30 sources. Are you recommending the medical profession  
should take a lower fee than what they consider is a  
desirable and reasonable and fair fee; is that what  
you are recommending?







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4 DR. RIOUX: I don't know whether I  
5 understand your question, sir. I just added that this  
6 requirement of the medical profession, which in order  
7 to safeguard these contacts with his patients desires  
8 that it be paid directly, if there are any additional  
9 charges the medical profession is ready to accept the  
10 charge, but we don't want an increase in the premium  
11 because it would be the Government which will have to  
12 undertake the collection, support the collection costs.

13 THE CHAIRMAN: That isn't the question.  
14 The question doesn't appear in this light. I think you  
15 will understand the question, it is an economic matter.

16 COMMISSIONER FIRESTONE: We will  
17 rephrase the question.

18 MR. BOUDREAU: Your question, Dr.  
19 Firestone, presupposes that the fact that the cheque  
20 being made out in the name of the patient will increase  
21 the inefficiency of the administration. However, I don't  
22 know the basis of your question. You would have to  
23 prove this hypothesis before raising this supposition.

24 THE CHAIRMAN: It is already proven.

25 MR. BOUDREAU: But I don't recognize the  
26 fact that if the cheque is made out in the name of one  
27 or the other, I don't see there is any consequence. I  
28 don't see that this will increase the administration  
29 costs.

30 THE CHAIRMAN: Well, we should accept  
the answer whether it helps us or does not help  
us.

COMMISSIONER FIRESTONE: May I restate the





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4 question, Mr. Rioux. If a physician examines hundreds  
5 of patients a month and at the end of the month he  
6 prepares one statement which he submits to the Commission  
7 and he receives one cheque covering the 200 patients  
8 he is seeing during the month, would you not say that  
9 the cost of administering the one statement and the  
10 one cheque would be less than the cost of this doctor  
11 sending out 200 bills to 200 patients, 200 patients  
12 sending 200 bills to the Commission and the Commission  
13 examining 200 bills and issuing 200 individual cheques  
14 going back to all the patients and the patients sending  
15 it all back. Would you not say that one statement a  
16 month per doctor and one cheque would involve less  
17 administrative cost than sending out 200 cheques and  
18 200 statements. That is just a simple economic question.

17 DR. RIOUX: From the administration  
18 standpoint I agree that there will be more complications  
19 than if the cheque were sent directly to the doctor  
20 covering all his expenses. However, we have the  
21 impression that the harmony, I reiterate, the harmonious  
22 contact which should obtain between the patients and  
23 the doctors require that the administration should pay  
24 those costs. The administration should accept such a  
25 situation in the interest of harmonious relations  
26 between the doctors and their patients. These harmonious  
27 contacts are obligatory, are necessary.

27 THE CHAIRMAN: The patient goes to the  
28 doctor's office and he will pay for each medical  
29 treatment, that is the contact you mean?

29 DR. RIOUX: It is difficult to explain.  
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4 There are things of a sentimental nature, this is one  
5 of those elements, excuse me for saying this, but in  
6 the Province of Quebec we are motivated by the old  
7 French humanity. Now, at such a time when an insurance  
8 plan will be introduced this motivation must continue.  
9 Now, we wish to safeguard wherever possible this  
10 principle, we want to safeguard this harmony. It is  
11 very hard for us to explain.

12 THE CHAIRMAN: Why is it difficult to  
13 understand?

14 DR. RIOUX: If this will cause administra-  
15 tion problems these problems are difficult, I know.

16 THE CHAIRMAN: But it is not difficult.  
17 I do not understand the situation in Quebec.

18 DR. RIOUX: Well, it is a matter which  
19 involves contacts. It is difficult to discuss in figures.  
20 We are sentimental people in the Province of Quebec and  
21 I hope that something remains of this.

22 THE CHAIRMAN: But I do not understand  
23 what you mean.

24 DR. RIOUX: Well, it is a very difficult  
25 thing to explain, sir, I can't explain it any more than  
26 I have already done. This is something about  
27 humanitarian principles which we are presently trying  
28 to conserve and safeguard.

29 THE CHAIRMAN: Let us say I am the  
30 patient, I receive a cheque, I put this cheque in an  
envelope and I put it in the mail box. Now, what  
personal contact is there there?

DR. RIOUX: Well, the very gesture you







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4 make. A great many people will do the same thing and a  
5 great many people want to do this thing and we have  
6 seen this. The Quebec health services have participated  
7 in such cases and they are ready to pay the doctor  
8 directly. The administration has noted that many  
9 patients prefer to receive their cheque directly and  
10 pay directly but there can be certain trouble or  
11 problems. We think the patient should be free to pay  
12 for himself.

13 DR. LACHAINE: Now, if I remember  
14 correctly in Germany an experiment was conducted about  
15 1930 when they tried such a system for a short period.  
16 This experiment failed. Afterwards France also studied  
17 the problem and came to the conclusion it would be  
18 preferable to have a relationship between the patient  
19 who receives the payment and could check the doctor's  
20 bill rather than have a third party pay the doctor  
21 where a whole corps of experts would be required to  
22 check the validity of the bill. It would be more  
23 expensive if a third party were eliminated but, on the  
24 other hand, there would be better contact between the  
25 doctors and patients. I read this in a little pamphlet  
26 on the subject and I can give to you. This reports  
27 the experiment in Germany.

28 DR. WARD: Just to make one commentary.  
29 Not only would there be greater expense in the system  
30 which is envisaged by Dr. Rioux, but there would be the  
disappearance of approximately 10% of the whole thing,  
the money going into the pockets of the patients. One  
is reminded of the story of one coloured gentleman who





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4 sent a bottle of whiskey to another coloured gentleman  
5 by his nephew and he said that was like sending letters  
6 by rabbit. That is what would happen in approximately  
7 15% of the people who are indigent or nearly so who have  
8 not bread for their children and it is a terrible  
9 temptation to put that cheque into their hands which  
10 would be needed for food. There would be another 10%  
11 for the costs of administration that would have to be  
12 collected or have to be written off or something like  
13 that. That is the biggest thing I can see. In the  
14 Blue Cross if a person is calling a participating  
15 physician their fees are paid, it is true it is an  
16 indemnity plan but their fee is paid directly to them  
17 and that is a thing greatly valued by the physician in  
18 Quebec and nearly every physician in Quebec is a  
19 participating doctor in the Blue Cross.

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21 COMMISSIONER FIRESTONE: If this works  
22 under the Blue Cross why not under the proposal that  
23 is before us now?

24 DR. WARD: I think it would.

25 COMMISSIONER FIRESTONE: Well, what are  
26 the reasons you are recommending against it?

27 DR. WARD: I am not recommending  
28 against it.

29 COMMISSIONER FIRESTONE: I take it there  
30 are differences of opinion as to whether the system  
you have recommended is in the best interest of both  
doctors and patients.

DR. RIOUX: Certainly the -- I should  
have said we have prepared our plan very quickly but our





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and that is a thing greatly valued by the physician in  
Quebec and really every physician in Quebec is a

participating doctor in the Blue Cross.  
COMMISSIONER FLEMING: Is this work

under the Blue Cross why not under the proposal that  
is before us now?

MR. WARD: I think it would.  
COMMISSIONER FLEMING: Well, what are

the reasons you are recommending against it?  
MR. WARD: I am not recommending

against it.  
COMMISSIONER FLEMING: I take it that

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you have recommended is in the best interest of both  
doctors and patients.

MR. WARD: Certainly the -- I should  
have said we have prepared our plan very quickly but we



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4 opinion may change in the coming days. This is a major  
5 objection and if you will allow us we will reconsider  
6 this matter.

7 DR. GAGNON: I can answer the question,  
8 namely, the nature of the relationship between the  
9 doctor and his patients; this relationship is an  
10 intimate personal one, a relationship of confidence  
11 which has been established. This relationship appears  
12 after treatment, it appears in the great gratitude of  
13 the patient towards his doctor which is expressed in  
14 the form of the fees which the patient pays to the  
15 doctor.

16 DR. RIOUX: May we consult the brief  
17 here to show there is no diversification on this point.  
18 Article 146 we state that it is important to respect  
19 the right of a patient to personally pay his bills.  
20 In other words, we admit that this patient who must  
21 pay naturally with the cheque that the administration  
22 sends him, this is in article 246 in our brief and I  
23 think there is no diversions here.

24 COMMISSIONER FIRESTONE: If the patients  
25 were very happy to have the Commission look after the  
26 payment of the bill because he paid the premium would  
27 the doctors object to that?

28 DR. RIOUX: No.

29 COMMISSIONER FIRESTONE: If the people  
30 of the Province of Quebec want the Commission to pay  
because it stops them sending cheques for nothing, would  
the doctors go along with such a proposal?

DR. RIOUX: Would you be kind enough to







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3 repeat your question?

4 COMMISSIONER FIRESTONE: As I understand  
5 this quotation which you offer us it is suggested that  
6 this proposal is based on your recognition of the  
7 sacred right of the patient to pay his medical bills.  
8 Now, if the patient were happy to have the Commission  
9 pay the bills directly to the doctor because he has  
10 paid a premium to the Commission, would you agree with  
11 this as long as the patient would let the Commission  
12 pay the bills?

13 DR. RIOUX: We would have no objection  
14 if the patient who is a citizen of Quebec, if this  
15 patient wishes to have the Commission pay. We would have  
16 no objection and the reason for this is to avoid the  
17 patient because he is such ---

18 COMMISSIONER FIRESTONE: May I turn  
19 to another aspect of this insurance plan which you have  
20 proposed. As I understand it it is a joint private  
21 and public plan provided in the sense that those people  
22 who can afford to pay the premiums pay them and public  
23 in the sense that the government pays for those that  
24 cannot afford to pay the premium. The government  
25 participates in the administration of the plan by  
26 nominating certain members to the Commission, is that  
27 the essence of your plan?

28 DR. RIOUX: Yes, sir.

29 COMMISSIONER FIRESTONE: Now, we are  
30 using the phrase "Government", when you speak of  
government do you refer to the government of the Province  
of Quebec?





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4 DR. RIOUX: It is the basis of our  
5 brief, this is the basis of our brief because the first  
6 ten pages of it we stated that we were convinced that  
7 this plan should be placed under provincial administra-  
8 tion. We feel, therefore, that the province should  
9 participate in this plan and not the Federal Government.

10 COMMISSIONER FIRESTONE: If I might  
11 pursue this particular aspect a little; first, we have  
12 at the present time a hospital insurance plan in  
13 operation to which the Federal Government makes a  
14 contribution in every province including the Province of  
15 Quebec. As I understand it in your brief you are opposed  
16 to this plan as it is presently in operation and  
17 financed, is that correct?

18 DR. RIOUX: Well, as far as I am  
19 concerned the Province of Quebec is the last province  
20 to have accepted participation in this plan. Naturally  
21 we had objections but the province was almost forced  
22 to accept this. It was naturally inconceivable that  
23 the province of Quebec should remain outside such a plan.  
24 The Prime Minister of the province said only yesterday,  
25 excuse me for repeating it today, probably you have  
26 read it, but he said it was important for the province  
27 to have the necessary funds in order to exercise what  
28 it considers to be a right. Therefore, we feel this  
29 plan should be placed strictly under the provincial  
30 government's authority.

COMMISSIONER FIRESTONE: In other words,  
what you say is you are putting up with this plan on  
an interim basis in the hope that some day the Federal-  
Provincial fiscal relations will be so resolved that the







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4 province would obtain increased revenue and, therefore,  
5 would be able to take the plan over 100%; is that the  
6 point of view you hold?

7 DR. RIOUX: Well, we hope that someday  
8 the Federal Government will go beyond this ---

9 COMMISSIONER FIRESTONE: Therefore you  
10 are accepting this plan as the best interim arrangement  
11 that can be made in the present stage of Federal-  
12 Provincial fiscal relations?

13 DR. RIOUX: That is right.

14 COMMISSIONER FIRESTONE: And now, you  
15 know very well that the sort of proposal that has been  
16 suggested of Federal-Provincial fiscal arrangements  
17 that will meet the needs of all provinces and the  
18 federal government has been very difficult to develop  
19 because we have in Canada provinces that are wealthy  
20 and provinces that are less wealthy, and, therefore,  
21 what suits the provinces that are wealthy might not  
22 suit the provinces that are less wealthy. For 95 years  
23 Canada has tried to resolve the Federal-Provincial  
24 fiscal arrangements and so far it has not succeeded.  
25 Now, since you feel that this scheme that you are  
26 proposing on the medical care side should be provincially  
27 operated, would you feel that other provinces that are  
28 in a less fortunate financial position than the  
29 province of Quebec should not have access to some  
30 Federal contribution to help them with a medical care  
plan simply because the Province of Quebec does not  
want to be party to such a plan?

DR. RIOUX: Well, in order to be consistent







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4 we ourselves recognize that the provinces should be  
5 autonomous in any health plan, the State should act  
6 as the head of the family, it should supervise the  
7 reactions of its children but not interfere in their  
8 personal affairs. In this plan it is felt that the  
9 Provincial Government can carry this on without inter-  
10 ference from the Federal Government because the  
11 Federal Government -- the richer provinces could come  
12 to an agreement amongst themselves, otherwise we would  
13 not be consistent with the proposal in our plan and  
14 in our previous statement.

15 COMMISSIONER FIRESTONE: Assuming that  
16 is the ideal that you have suggested to us, a division  
17 of fiscal responsibility and revenue collection would  
18 take a considerable time, it has taken 95 years and we  
19 have not resolved it yet; let us hope it will be less  
20 time than that but it could take many, many years.  
21 Would you feel that in the interim it might not be  
22 desirable to think of some plan which would make it  
23 possible to every province to develop its own provincial  
24 medical care insurance programme and some that do not  
25 have enough resources with the help of the Federal  
26 Government and some that feel they do not need the  
27 help without, can you visualize such a plan developing  
28 over the next few years and covering what we call an  
29 interim period? We do not know how long that interim  
30 period will be, but would you feel that such a plan  
could develop?

AG/hm 28 DR. RIOUX: Once again, to be consistent  
29 with our principles, we are convinced that if our  
30 province will have sufficient income revenue available,





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4 it will be able to organize its own individual plan,  
5 and this can be done rather quickly. Provided that the  
6 necessary finances are available this can be done. I am  
7 not an economist, excuse me for speaking from the point  
8 of view of a doctor.

9 COMMISSIONER FIRESTONE: I understand,  
10 and we appreciate your point of view as a doctor, but  
11 you realize, sir, that for 95 years we have not been  
12 able to achieve this ideal of Federal-Provincial  
13 distribution of fiscal authority, and my specific  
14 question to you is this, doctor, and perhaps if you  
15 wish me to address the question to Mr. Boudreau I will  
16 rephrase the question so that he will have the question  
17 as a whole.

18 Now, Mr. Boudreau, given the fact that  
19 Canada has found it difficult for 95 years to arrive  
20 at an adequate distribution of fiscal authority in  
21 revenue collection and other obligations, the question  
22 before us is whether we could as an interim arrangement  
23 until all these difficulties are resolved, visualize  
24 a national plan, whereby the Federal Government would  
25 offer a 50% contribution to the provinces to establish  
26 a provincial medical care insurance plan, provincially  
27 operated and provincially financed to the extent of  
28 the provinces contributing to it, leaving the whole format  
29 of the plan to the province, and therefore leaving the  
30 approach similar to what we have in the field of  
hospital insurance, but applying it to the subject of  
medical care insurance, with the understanding that at  
the time when the fiscal problems are resolved, and the







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4 ideal which you are aiming at is achieved, that a new  
5 arrangement will be worked out that will suit everybody?

6 MR. BOUDREAU: Well, you must recognize,  
7 Dr. Firestone, that your suggestion contains certain  
8 dangers. Experience has shown that in this sphere of  
9 activity, where Ottawa has already begun certain  
10 interventions, certain complications have arisen, so  
11 there are certain dangers involved in the suggestion,  
12 but I believe you are right in saying that for 95 years  
13 we have been trying to redistribute the fiscal burdens,  
14 and we still have not succeeded, but it is true that  
15 we are trying to evolve a system of medical care, a  
16 generalized system of medical care. Here again there  
17 are difficulties involved, so I believe that if we  
18 tried to solve the problem of medical care by tackling  
19 the fiscal aspect of the problem the time for solving  
20 this problem would be just as long as if we tackled the  
21 purely medical aspect of the problem.

22 Now, we all belong to a confederation,  
23 and naturally certain provinces are richer than others.  
24 However, there is a principle in Canada which involves  
25 the idea of a fair equation. Now, this principle is  
26 an unconditional one. Therefore the ideal situation  
27 would be one in which all the provincial governments  
28 would have a per capita revenue, which would be comparable  
29 amongst themselves.

30 Now, once they have this comparable  
revenue available to them, then the provinces would all  
be placed on the same footing. At such a time those  
provinces who wished to use these funds for health







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4 purposes in order to implement a medical plan would be  
free to do so.

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6                   Once this financial inequality of the  
7 provinces has been eliminated, then the main obstacle  
8 to the establishment of a medical care plan would also  
9 be eliminated. I believe that this principle of fair  
equation does not present an insurmountable obstacle.

10                   COMMISSIONER FIRESTONE: Mr. Boudreau,  
11 would you then recommend the introduction of a nation-  
12 wide medical care insurance plan on a provincial basis  
be deferred until the fiscal problems are resolved?

13                   MR. BOUDREAU: I believe I would like  
14 to refer the question to Dr. Rioux.

15                   DR. RIOUX: It is difficult to answer  
16 that question, sir, very difficult. Naturally, if  
17 health requirements are urgent, it would be difficult  
18 to feel that the people would not require immediate  
19 care. However, if you allow me, we would like to  
20 maintain our position, that position which we have held  
21 from the very outset, namely we prefer that the  
provincial government should implement this plan.

22                   We recognize that your objections are  
23 very important ones, but if the people of the province  
24 demand that a health plan should be immediately set up  
25 in the province before the fiscal aspect of the problem  
26 should be solved, it is for the public to decide this,  
because it is the taxpayer who pays for it.

27                   Now, if the people of the province  
28 demand that before the solution of any fiscal problem  
29 is applied, medical health care should be provided, well,  
30 if this is the demand of the people it is for the people

purposes in order to implement a medical plan would be

Once this financial inequality of the provinces has been eliminated, then the main obstacle to the establishment of a medical care plan would also be eliminated. I believe that this principle of fair

equation does not present an insurmountable obstacle. Would you then recommend the introduction of a nationwide medical care insurance plan on a provincial basis be deferred until the fiscal problems are resolved?

MR. BOGDAN: I believe I would like

to refer the question to Mr. Rioux.

MR. RIoux: It is difficult to answer

health requirements are urgent, it would be difficult to feel that the people would not require immediate

however, if you allow me, we would like to maintain our position, that position which we have held from the very outset, namely we prefer that the provincial government should implement this plan.

We recognize that your objections are very important ones, but if the people of the provinces demand that a health plan should be immediately set up in the province before the fiscal aspect of the problem should be solved, it is for the public to decide this, because it is the taxpayer who pays for it.

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demand that before the solution of any fiscal problem is applied, medical health care should be provided, well, if this is the demand of the people it is for the people



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3 themselves to assume the responsibility and to accept  
4 the intervention of the Federal Government in this  
5 provincial plan. It is not we who require this, it is  
6 the people who demand this.

7 DR. BONIN: Sir, may I add that it  
8 didn't take so much time to solve the problem for the  
9 universities. We receive certain subsidies from the  
10 Federal Government, but taxes will compensate for this,  
11 and this imposes of course obligations on the Federal  
12 Government as a consequence.

13 COMMISSIONER FIRESTONE: When we were  
14 in Quebec City at the beginning of this week, we had  
15 the unions submit a brief, and they expressed the  
16 opinion that there was great urgency of introducing  
17 medical and health care insurance plans in the Province  
18 of Quebec. We have had similar submissions by other  
19 groups all across the country, and therefore, from what  
20 we have heard, there seems to be a popular demand for  
21 such a programme.

22 Do I understand you correctly to say  
23 that if there is such a popular demand for a programme,  
24 that you as doctors of the Province of Quebec would  
25 submit such a plan, which on an interim basis may  
26 include a federal contribution to such a plan, which  
27 would be provincially administered, and provincially  
28 operated?

29 DR. RIOUX: If this were correct, of  
30 course I respect all that you have said, if the public  
of this province, if the citizens demand the immediate  
establishment before any fiscal questions are solved  
of a health insurance plan, then of course we shall be





themselves to assume the responsibility and to accept the intervention of the Federal Government in this provincial plan. It is not we who require this, it is the people who demand this.

DR. BONIN: Sir, may I add that it didn't take so much time to solve the problem for the universities. We receive certain subsidies from the Federal Government, but taxes will compensate for this, and this imposes of course obligations on the Federal Government as a consequence.

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Do I understand you correctly to say that if there is such a popular demand for a programme, that you as doctors of the Province of Quebec would submit such a plan, which on an interim basis may include a federal contribution to such a plan, which would be provincially administered, and provincially operated?

DR. RISQUE: If this were correct, of course I respect all that you have said, if the public of this province, if the citizens demand the immediate establishment before any fiscal questions are solved of a health insurance plan, then of course we shall be



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3 obliged to accept that, and we shall continue to provide  
4 medical care with the plan that we present to the  
5 people, with the reductions that we propose, and which  
6 has not yet been accepted by the medical profession,  
7 but we believe that they will accept it in the future  
8 months.

9 COMMISSIONER FIRESTONE: This is a very  
10 enlightened attitude to take, and thank you Dr. Rioux,  
11 Dr. Bonin, Dr. Ward and Mr. Boudreau and all your  
12 associates for your comments. Thank you very much.

13 THE CHAIRMAN: And as for me, and the  
14 other commissioners, I would like to say thank you also.

15 Now, with regard to what has already  
16 been said by the previous speakers and the reports you  
17 have submitted, I would like to repeat with regard to  
18 these briefs, I would like to say what I said in Ottawa  
19 in the September hearings, when I stated that by  
20 beginning our work in the field of health, and I would  
21 say that we have no intention of intervening, or ignoring  
22 the rights of the provinces. Our terms of reference  
23 are to conduct an enquiry into the present needs and  
24 the future needs with regard to health services for the  
25 population of Canada, and this shall be compatible with  
26 constitutional distribution of the legislative powers,  
27 and that is how we are conducting our enquiry.

28 DR. RIOUX: Mr. President, we were  
29 convinced right from the start of what you have just been  
30 saying. That is quite true, and you will allow me, since  
we are coming to the end, to thank you and the members of  
your Commission for the kind reception you have given us,







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and the kind reception of the questions we have asked.

THE CHAIRMAN: We will take a short  
break.

---A short recess.

THE CHAIRMAN: If we could come to order  
we will proceed. Our next submission will be from the  
Canadian Paediatric Society. The exhibit number will be  
223 and the french version will be exhibit 223A.

---EXHIBIT NO. 223:

Submission of the  
Canadian Paediatric  
Society.

---EXHIBIT NO. 223A:

French version of the  
submission of the  
Canadian Paediatric  
Society.





SUBMISSION OF  
CANADIAN PAEDIATRIC SOCIETY

APPEARANCES: Dr. H. Charbonneau  
Dr. R. L. Denton  
Dr. J. C. Rathburn  
Dr. L. Bray  
Dr. W. Tidmarsh

THE CHAIRMAN: Dr. Rathburn.

DR. RATHBURN: Mr. Chairman, I would like to introduce my advisers. On my extreme right, Dr. Henry Charbonneau, Professor of Paediatrics, University of Montreal. On my immediate right, Dr. R. L. Denton, Associate Professor of Paediatrics McGill University. On my immediate left, Dr. L. Bray, a paediatrician of Saskatchewan and at the far left, Dr. Tidmarsh, our Secretary. I would like to commence, sir, by reading the recommendations.

The Canadian Paediatric Society was founded in 1923. I think we represent the majority of paediatrists in Canada as 418 of 624 certified specialists are members of our Society.

R-1 Paediatrics is the specialized care of children between the ages of birth to 18 years. This, therefore, involves the care of about one-third of the population. Because of these large numbers, we believe that the present trend of specialization in paediatrics should continue. (p. 1)

R-2 As a basic principle, the Canadian Paediatric Society believes that the services of a paediatrician should be made available to every Canadian



# NEW PEDIATRIC SOCIETY

## APPEARANCES:

Dr. L. (phonetic)  
Dr. J. L. Denton  
Dr. G. C. Denton  
Dr. J. L. Denton  
Dr. W. T. Denton

Dr. J. L. Denton, Mr. Chairman, I would like to introduce my advisers on my extreme right, Dr. Henry Charbonneau, Professor of Pediatrics, University of Montreal. On my immediate right, Dr. R. L. Denton, Associate Professor of Pediatrics McGill University. On my right also left, Dr. J. L. Denton, pasted down of last year and at the far left, Dr. J. L. Denton, our Secretary. I would like to introduce, sir, by reading the recommendations.

The Canadian Pediatric Society was

founded in 1924. I think we represent the majority of

pediatricians in Canada as 118 of the certified specialists

are members of our Society.

R-1 Pediatrics is the specialized care of

children between the ages of birth to 15 years. This,

therefore, involves the care of about one-third of the

population. Because of these large numbers, we believe

that the present trend of specialization in pediatrics

should continue. (p. 1)

R-2 As a basic principle, the Canadian

Pediatric Society believes that the services of a

pediatrician should be made available to every Canadian



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4 infant and child. (p. 6, B-1)

5 R-3 The paediatrician occupies a unique  
6 role in the community with skills and special knowledge  
7 related to children. The great majority of paediatric  
8 specialists are in active practice concerned with total  
9 infant and child care. Part of their time is utilized  
10 in a consultative capacity for general practitioners  
11 and other specialists. (p. 3, A-1)

12 R-4 As the paediatric specialist is highly  
13 trained, equivalent to that of the other medical  
14 specialties, it is essential to utilize his time to the  
15 maximum -- to the maximum efficiency there is. Increased  
16 utilization should be obtained in school medical  
17 services, in preventive medicine through immunization  
18 clinics, for well baby clinic facilities, as consultants  
19 in civic, metropolitan, provincial and federal child  
20 health departments, as well as in administrative roles  
21 in these departments, in physical fitness programmes  
22 and particularly, as part-time paediatricians in an  
23 academic environment where they will bring practical  
24 information to the undergraduate students. (p.12, C-2)

25 R-5 Increased efficient utilization of the  
26 paediatrician's time could be made through the extension  
27 of consulting travelling teams which visit outlying  
28 areas. (p.6, B-1)

29 R-6 Increased use of newer methods of  
30 communication such as radio-telephone, possibly television  
methods, would provide a more rapid consulting service.  
(p.6, B-2)

R-7 The various child health programmes should







be apart from private practice but should be supervised by paediatricians. (p. 12, C-2)

R-8 Voluntary agencies should be encouraged in order to satisfy new demands from the public as they arise. Voluntary agencies should be co-ordinated by some general council such as the proposed Canadian Rehabilitation Council for the Disabled. (p. 9, B-7)

R-9 The National Health Grants should be increased to make more funds available for new construction and redevelopment of existing construction, as well as increased research and services. (p. 20, J-2)

R-10 Improved paediatric care through the Indian and Northern Health Services for children is needed. (p. 10, B-11)

R-11 Increased psychiatric and neurological facilities are urgently required for children. (p. 10, B-10)

R-12 Some method of financial aid for catastrophic illness is urgently needed. (P. 11, B-13)

R-13 Increased public education in the matters of child health is needed, particularly as regards nutrition, the prevention of infectious diseases, in the understanding of normal growth and development and accident prevention. (p. 8, B-6)

R-14 Increased development of diagnostic facilities in children's units for the use of practicing physicians is essential in order to improve health services. (p. 7, B-3)

R-15 Present paediatric personnel is inadequate to serve the population, there being 1 paediatrician to 29,000 gross population. It is





recommended that a satisfactory paediatrician - population  
ration would be 1 to 20,000. A more adequate distribu-  
tion of paediatricians is needed so that they are not  
concentrated solely in the larger centers. Inducement  
could be provided by making increased use of their  
specialized knowledge in school and public health  
services. (p. 12, D-1)

R-16 There must be greater recognition of the  
need for paediatric training in the curriculum of the  
general practitioner, particularly at the internship  
level. (p.15, E-2)

R-17 The numbers entering the paediatric  
specialty are small and their training long. Efforts  
should be made to utilize their services most  
effectively. (p. 14, D-3)

R-18 There should be increased support for  
training paediatric research scientists and fulltime  
clinical teachers. Funds should be provided to  
establish fulltime appointments for those who have been  
so trained. (p. 15, E-4, E-5)

R-19 There is a need to establish autonomous  
children's units in medical centers in order to increase  
the training facilities for paediatricians in Canada,  
as well as to provide specialized diagnostic and  
treatment facilities for children who require different  
types of equipment from that used for adults. It is  
recommended that there should be a paediatric bed for  
every 1000 gross population and, once adequate paediatric  
centers are established, peripheral paediatric wards  
in general hospitals should be developed. (p. 17, F-5)







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R-20 A realistic estimate of the cost of services now being rendered to Canadian children seems to be unavailable. It is recognized that the care of children in hospital is much more expensive than that in adult hospitals as children require closer supervision as well as more nursing hours for feeding, personal care, and administration of medicines. Insofar as hospital care is concerned, 19.4% of hospital services are rendered to children. (p. 18, G-1, G-2)

R-21 Methods of Financing:

There are no unique methods of financing children's programmes as separate from adult programmes. (p. 19, I-1)

R-22 Research:

Research remains a vital activity of all paediatric departments throughout Canada for the continuation and advancement of scientific knowledge in the problems of diseases in children. It is recommended that an increased budget be available to allow for the expansion of research facilities in the various scientific paediatric institutions across Canada. (p. 20, J-1, J-2)

R-23 Part-time Physician Personnel:

It is hoped that funds would continue to be available to encourage physicians to maintain an interest in clinical research and teaching on the basis of review of problems or follow-up of cases. This type of review is particularly important in terms of social research. (p. 21, J-3)

R-24 Research Grants:

It is hoped that the grants-in-aid







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4 available for research from the Medical Research Council  
5 and National Health Grants will be increased. It is  
6 recommended that the budget available for paediatric  
7 research be increased to about \$2,000,000 annually.

8 That will be increased about 7% per annum thereafter.

9 R-25 It is realized that all the foregoing  
10 recommendations will tend to reduce the loss to the  
11 country of many children's lives and minimize the  
12 resulting handicaps from illness and injury. It is  
13 emphasized, however, that these will produce an even  
14 more profound effect if the various factors which will  
15 raise the standard of living are taken into consideration.  
16 The active support of the social services, these are  
17 social welfare standards, is closely related to improved  
18 health and improved standards of living. (p. 12, C-2)

19 R-26 The Canadian Paediatric Society intends  
20 to continue its review of the needs for health services  
21 for children in Canada which have been under scrutiny  
22 since 1922. The Canadian Paediatric Society is willing  
23 at all times to co-operate with any agencies or groups  
24 that have this common interest. (p. 11, C-1)

25 THE CHAIRMAN: Thank you very much,  
26 Mr. Rathburn. This is a presentation on behalf of the  
27 paediatricians of Canada, of the whole country.

28 DR. RATHBURN: Yes.

29 THE CHAIRMAN: Perhaps I am going outside  
30 the immediate scope of your brief, but as you know,  
31 suggestions have been made in various provinces that  
32 there should be medical service plans and in every case  
33 where you have a plan suggested this question of the





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4 specialist naturally arises. Because you represent  
5 one specialist segment of the profession, naturally,  
6 I think we have to discuss some phases of where the  
7 specialist is going to fit into the practice of medicine  
8 in the future, and particularly now that your specialists  
9 -- ordinarily, most specialists never see a patient  
10 unless the patient is referred by a general practitioner  
11 or some other practitioner. Is it a fact, is the  
12 paediatric specialty developing into a point where they  
13 are called upon in the first instance more than by  
14 referral? Is that the way the specialty is developing  
15 in Canada?

14 DR. RATHBURN: This, sir, was in point  
15 of fact the way the specialty started. I think that  
16 we are frequently called in directly by the parent who  
17 estimated that a specialist was needed. The society as  
18 a whole feel that ideally all children should be looked  
19 after by paediatricians. Obviously the care would  
20 improve, hospital days shortened and so on.

20 THE CHAIRMAN: Just on that point, I  
21 don't want to interrupt you unduly, but does that  
22 presuppose the elimination of the family doctor at that  
23 stage? Does he disappear? Does the paediatrician become  
24 the children's family doctor?

25 DR. RATHBURN: This concept would do  
26 exactly that, sir, but actually this matter has been  
27 discussed, as you may imagine, in our society in great  
28 detail and the figure of 1 in 20,000 was selected with this  
29 goal in mind.

29 I might say there is a minority opinion  
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4 which is expressed probably best by our Education  
5 Committee that feels that this is an impracticable  
6 approach and the number of applicants for paediatrics  
7 are diminishing and the chances of achieving this with a  
8 falling off of medical registration as well are slender,  
9 so that it is the concept of the Education Committee  
10 which is composed mostly of the professors across  
11 Canada that we shall see a change towards a more  
12 consulting capacity where the mother will not bring her  
13 child directly but that they will see patients on  
14 referral.

15 THE CHAIRMAN: Is the answer more  
16 paediatricians rather than a change of existing systems?  
17 Should efforts be made to increase the recruitment of  
18 your specialty rather than permit this change that you  
19 see coming because of the shortage of paediatricians?  
20 I mean, what would be your recommendation in that  
21 regard, because you see we are rightly concerned with  
22 the problem of medical education and the trends in  
23 medical education.

24 DR. RATHBURN: Sir, ideally the great  
25 advantage would be to increase the recruitment. This  
26 would be ideal. I think we would provide better care  
27 for children, if a paediatrician was available on  
28 first call. Unfortunately, I think there is a second  
29 factor we have to bear in mind, and one the society are  
30 most concerned about is the possibility of lowering of  
standards, if one turns to other bodies and takes in  
people who are not adequately prepared or trained. Ideally  
I would like to see it so that all children could go to







Rathburn

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4 paediatricians directly. I am sure the care would  
5 improve.

6 THE CHAIRMAN: In a plan such as has been  
7 suggested by the Province of Saskatchewan where, in  
8 setting up the suggested schedule of fees, it is  
9 suggested that the fee paid by a person who goes  
10 initially to a specialist is that of a general practi-  
11 tioner's fee, and that a special fee is only paid when  
12 it is a question of referral. The whole concept would  
13 have to be accepted right through the plan, even in  
14 the matter of payment.

15 DR. BRAY: I think there is a public  
16 demand for specialists' services irrespective of how  
17 we feel about consulting. I practice in a small  
18 community.

19 THE CHAIRMAN: Doctor, I should know  
20 where you practise.

21 DR. BRAY: Moose Jaw. Patients do go  
22 directly to a specialist, many times probably when it is  
23 not necessary, but they feel this is what they want,  
24 and I think that this plays a big factor in a provincially  
25 sponsored medical plan. They may still be inclined to  
26 do this, even though they may have to pay a little  
27 differential as is outlined ostensibly in Saskatchewan.

28 THE CHAIRMAN: That is the way the Act  
29 reads.

30 DR. BRAY: That is the way the Act reads,  
so the demand of the patient may force us into looking  
after more patients when actually our time could be  
better spent on a consulting basis. We could look after





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4 more people, more patients profitably to the patient  
5 and to the doctors on a consulting basis than on  
6 looking after the patients directly off the street.

7 COMMISSIONER FIRESTONE: Who therefore  
8 would be getting better medical service by being  
9 looked after by a paediatrician. It may have other  
10 advantages besides just medical better service, the  
11 use of bed stay in hospitals, et cetera. There may be  
12 compensations for society as a whole?

13 DR. BRAY: That is right.

14 COMMISSIONER BALTZAN: Dr. Rathburn  
15 has a question?

16 DR. RATHBURN: I just wanted to add  
17 one comment. There may be compensations which make  
18 up an economic problem as to efficiency and whether or  
19 not certain jobs can be better performed by better  
20 trained general practitioners. This is a thing we  
21 have not quite solved yet, really.

22 COMMISSIONER VAN WART: There is a  
23 large volume of illnesses which are minor in nature and  
24 time consumin' which the services of the paediatrician  
25 are not needed for and the general practitioner can  
26 handle them very well and then have a consultant for  
27 the major sicknesses which we have been talking about.

28 DR. BRAY: I think one has to realize  
29 that there are general practitioners and there are  
30 general practitioners; some general practitioners, a  
good general practitioner has to be able to deal with  
children but there are several who do not want to be  
bothered with them. I think the training of general







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4 practitioners, as I see it, has to be improved. This  
5 is a matter for teaching centers but it is not only a  
6 matter for teaching centers, I think it is a matter  
7 for centers such as I come from. I am referring now  
8 to the group practice where a paediatrician or  
9 paediatricians can be included in groups. This is  
10 probably more in evidence in Western Canada than in the  
11 east and I think it is a field here that could be  
12 explored.

13 THE CHAIRMAN: We heard today that there  
14 is a recommendation for group practise in this province,  
15 they can see the advantages of it here.

16 COMMISSIONER BALTZAN: Dr. Rathburn  
17 and gentlemen, I take it that as a Canadian body you  
18 go on record with the principle of receiving patients  
19 that are not referred. That has already been asked  
20 but now as a Canadian body representing Canadian  
21 paediatricians, you go on record as having what we call  
22 walk-in patients which is different in relation to some  
23 other specialists?

24 DR. RATHBURN: Yes.

25 COMMISSIONER BALTZAN: I take it as a  
26 Canadian body you recommend that the paediatrician takes  
27 charge of the infant from as soon as the parents want  
28 it and carry on right through up to your stated age of  
29 eighteen and in so doing you would be rendered every  
30 kind of service to that individual so just where would  
your specialty come in? I am thinking of the fracture  
and other things.

DR. RATHBURN: Dr. Baltzan, the feeling  
is that the paediatricians would continue to limit their







Rathburn

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4 services, as they already have actually as a group,  
5 have restricted their services very severely following  
6 in the line of the internist which you are familiar  
7 with. By and large the majority of paediatricians do  
8 not undertake any surgery, any operative procedures  
9 whatsoever nor do they give anaesthetics as a general  
10 rule. It would be our feeling that this would continue  
11 in this rather restricted fashion acting as, shall we  
12 say, internists for an age group under 18 years.

13 COMMISSIONER BALTZAN: I think, in  
14 relation to the matter of payment from certain organiza-  
15 tions and prepaid medical services, you have already  
16 been asked that but when you start to follow your little  
17 patient till he becomes a big patient, would you carry  
18 it through on the basis of a specialist or would you  
19 make some modification? What would your plan be?

20 DR. RATHBURN: As a matter of society  
21 policies we quite frankly turned over the economics to  
22 the provincial medical societies and the Canadian Medical  
23 Association. We are an affiliated society. I have  
24 attended a couple of meetings towards the Royal Commission  
25 and the Ontario Medical Association and we feel that  
26 this was more their province than ours. If I could  
27 intimate as a person or individual, the feeling in  
28 Ontario is towards a differential fee schedule amongst  
29 paediatricians of Ontario.

30 COMMISSIONER BALTZAN: I am informed that  
we have heard just the contrary where prepaid medical  
services will only pay for a consultant and if the  
patient goes directly to the paediatrician then he gets





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the basic fee. I have your opinion, thank you very much.

Now, you speak of improving the standards and quality and you speak in terms of medical centers; my question is, do you favour separate children's hospitals?

DR. RATHBURN: Yes.

COMMISSIONER BALTZAN: Now, in the proportion of residents that qualify, do or do not, good, well organized paediatric department with a sufficient number of patients and clinical material, would they not serve greatly in the preparation of a number of specialists in paediatrics that you want? Would they alone be sufficient to qualify an individual to eventually become a specialist or would you want these people trained in paediatrics to go only to children's hospital?

DR. RATHBURN: Sir, the present training programme is laid down, as you know, by the Royal College of Physicians of Canada and very few hospitals are accepted for full training. These are by and large children's hospitals or autonomous children's hospitals or units within general hospitals. It is our feeling that for post-graduate training the children's hospital is essential not only for child practice training but for specialist training for only there can you have a group that is engaged in research and teaching and practising a specialty at what we consider this higher level.

COMMISSIONER BALTZAN: You would not imply that one starting a specialty must begin at this top







Rathburn

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4 rate complete organized center for training paediatricians?  
5 They might start, say, in our teaching hospitals  
6 across the country and receive their basic training  
7 at one or clinical experience in a well organized  
8 department of paediatrics and get their finishing  
9 touches at such schools as you mention.

10 DR. RATHBURN: Well, it is possible  
11 under the present set-up to approve hospitals for there  
12 are some smaller hospitals where a candidate may spend  
13 one year of his training and it is usually restricted  
14 to one year in the smaller units and then they must  
15 move to the more advanced children's hospitals to complete  
16 their training.

17 COMMISSIONER BALTZAN: Just to clarify  
18 that, I think I have mostly what I want to know but there  
19 are in some provinces medical centers and in these  
20 provinces they are not children's hospitals but in some  
21 of these schools you can get complete training and  
22 qualify by writing an examination for a specialist.  
23 You would prefer as a Canadian society that they receive  
24 their training at a large center?

25 DR. RATHBURN: At a large children's  
26 hospital, yes, sir.

27 COMMISSIONER BALTZAN: And you say here  
28 there is one paediatrician for 20,000 gross population  
29 and I am curious about how you make up that assumption  
30 of the ratio, by what means?

DR. RATHBURN: We took the population  
of Canada and then I obtained from the Royal College  
the names of all the certified paediatricians in Canada  
and obtained from the french society the names of the







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French Quebec certified paediatricians who did not belong to both societies and then we took and divided one into the other and this is the figure.

COMMISSIONER BALTZAN: And if one looked at your original premise that you want to have this child looked after in the ideal way you would want a much greater ratio?

DR. RATHBURN: Yes.

COMMISSIONER BALTZAN: What would that be?

DR. RATHBURN: Well, to take it down to all children would require a ratio of about one in 10,000 approximately to gross population and this is a tremendous number of paediatricians.

COMMISSIONER BALTZAN: I hope you succeed, thank you very much.

COMMISSIONER VAN WART: Referring to R-8 and also it is described in page 9, E-7 a proposed Canadian Rehabilitation Council for the disabled, that does not exist at the present time, it is not in existence, is it?

DR. RATHBURN: A name alone at the present moment.

COMMISSIONER VAN WART: Would you explain how it would be constituted and its function a little more definitely?

DR. RATHBURN: Well, the fundamental idea is to have a council in which all the voluntary agencies who are concerned with disabled persons, both children and adults are members and by so doing there





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4 would be increased communication between the various  
5 agencies for it has been our experience that many of  
6 them do not know what the other is doing. And secondly,  
7 that there is not infrequently considerable overlap and  
8 we may find two or three agencies looking after one  
9 child not knowing that the other was doing it. Finally,  
10 one was concerned with establishing standards of  
11 medical care and management uniformly for these various  
12 groups based on the best medical and paramedical  
13 division that we could obtain. It was with this idea  
14 plus some budgetary supervision so that we could ensure  
15 public support that such a council was envisaged.

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17 COMMISSIONER VAN WART: That is on a  
18 national level and would have provincial subdivisions  
19 would it?

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20 DR. RATHBURN: Yes sir, we have already  
21 a move on in Ontario to establish such a council and I  
22 see in yesterday's paper that Montreal is starting a  
23 combined health drive too.

24 COMMISSIONER VAN WART: And they then  
25 would be co-ordinated by a Canadian council?

26 DR. RATHBURN: That is the idea.

27 COMMISSIONER VAN WART: Coming now to  
28 B-10 on page 10, speaking about disturbed children, you  
29 advise that clinics be set up across the country for  
30 this purpose. Is it your idea that there be children's  
mental health clinics in conjunction with the overall  
public health clinics or that they be separate children's  
clinics associated with children's clinics for other  
disorders and so on? Which plan do you have in mind?



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8-10 on page 10, speaking about disturbed children, you  
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DR. RATHBURN: Sir, the management and care of children who are mentally retarded has for a long time been disassociated from general medical care and placed under government because of the high economic problem. It is our feeling that in the interest of diagnosis and again in the prevention or retention of children unnecessarily in mental hospitals that these should be extremely carefully diagnosed for today we are on the threshold of advances in this field. Many of these cases are now treatable if they are treated or diagnosed early enough and if we can insure that they get a full, careful assessment before they are certified for a mental hospital I am sure we would save the country thousands of dollars.

DR. BRAY: There are two areas mentioned, one is the mentally retarded child and I can only speak from my own personal experience in Saskatchewan. We have two institutions looking after the mentally retarded children, one at Moose Jaw and one at Prince Albert. It is my feeling and the feeling of our society that with such institutions there should be paediatric consultation services available at least and I do not think it is provided in all these institutions, it does not apply across Canada. The other aspect is the emotionally disturbed child and for those I think we would be in favour of adding to mental health clinics they have the availability of child guidance clinics. This is done in some areas. Again I can only speak from personal experience but we attempted this in Moose Jaw where we have a very active mental health







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4 clinic but for lack of personnel, not only on the  
5 psychiatric side but social workers, psychologists, et  
6 cetera, we have not been able to make a go of it. We  
7 attempted it and hope still to be able to do it but  
8 there are these two areas where child guidance clinics  
9 could cut down on the problem of the children at school  
and home.

/AG/hm  
10 COMMISSIONER STRACHAN: Gentlemen, I  
11 have no reason to question why you choose the age of  
12 18, but I am wondering how you convince the average boy  
13 and girl of 18 today that they are children. I know  
14 one cannot do it in dentistry.

15 Might I, before you proceed to answer,  
16 might I ask along with that, if I may assume the privilege  
17 of dividing the children into three groups, from birth  
18 to six years of age, six to twelve, and twelve to  
19 eighteen. That may not be your division, but in that  
20 relationship what would be the percentage of patients  
that you have in those groups, or any group that you  
wish to choose?

21 DR. RATHBURN: As regards the definition  
22 of 18, I was expecting to be questioned on this early,  
23 because this is a change in definition. The accepted  
24 one for years has been up to 15 years of age. In the  
25 past decade paediatricians have become increasingly  
26 aware of the problem of the adolescent child, and it  
27 has been the experience of many of us in practice that  
28 at around 15 the child has known you all its life. You  
29 are sort of like an uncle, and they consider you to be  
30 their doctor, and suddenly they are taken and put into a





Rathburn

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3 whole new environment, and many of them are a bit  
4 unhappy. Now, there are problems with this age group,  
5 so much so that we are contemplating in London  
6 establishing a special clinic, such as Montreal has  
7 already established, and there have been, as you know,  
8 special hospital units.

9 These children are unhappy with adults  
10 in adult hospitals. They are also unhappy in children's  
11 wards, and they are now establishing adolescent wards,  
12 where these children are served hamburgers, and the like,  
13 and this they think is wonderful, and all the Coke they  
14 can drink, and I am sure the dentists will be upset.

15 COMMISSIONER STRACHAN: Let's eliminate  
16 those wards.

17 DR. RATHBURN: In other words, treating  
18 them as a unit, and this has achieved considerable  
19 success in some countries.

20 As to the numbers, I cannot give you  
21 offhand, I am sure the Department of Vital Statistics  
22 has this available. I have some figures in my bag.

23 COMMISSIONER STRACHAN: Thank you Dr.  
24 Rathburn. I am sure that is of interest to all, and  
25 I would like to follow up Dr. Baltzan's question  
26 regarding the ratios. You have mentioned the ratio of  
27 one paediatrician to the gross population. What would  
28 it be in respect to the patients which you treat in  
29 these various figures, one to 29,000, one to 20,000,  
30 and one to every 10,000. What would be the number of  
paediatric patients in those?

DR. RATHBURN: Well, a third of the







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population are children from presently about 12 to 15 per cent of children are being looked after by paediatricians, but therefore 85% are not.

COMMISSIONER STRACHAN: Well, I think you made the point that about a third of the population are between 0 to 18?

DR. RATHBURN: Yes, in the 1960 survey.

COMMISSIONER STRACHAN: Thank you.

COMMISSIONER FIRESTONE: Dr. Rathburn, on the bottom of page 8 and the beginning of page 9, your brief says, and I quote:

"It is a national disgrace that there  
"are still many cases of vitamin  
"deficiency in Canada each year".

Could you elaborate please?

DR. RATHBURN: Yes sir, the paediatricians for years have carried on a programme of education on nutrition, and the incidence of rickets and scurvy have fallen very rapidly. Now, everything was fine, and since we all became a little complacent until about five years ago, when four centers, particularly in Canada, started reporting new cases of scurvy, and these have risen steadily, so that this year immediately past some 50 cases of scurvy have been reported in mainly Winnipeg, Toronto, Halifax and Newfoundland.

Now, we feel that we as physicians are failing, quite frankly, in our job in public education to have this exist in a supposedly wealthy State, and one just cannot condone this, sir.

COMMISSIONER BALTZAN: Where does this







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3 neglect come in, or who is at fault?

4 DR. RATHBURN: I think the fault lies  
5 on many shoulders. I think as paediatricians we must  
6 go out and do more public education, and we have  
7 mentioned in our brief the fact that we feel paediatricians  
8 and publicity budgets for health departments should be  
9 increased. We have produced this year, in collaboration  
10 with the Canadian Medical Association, a short filmette  
11 on scurvy, and we are trying to stimulate interest on  
12 this. We are running a continuing survey on the  
13 incidence of scurvy in Canada with our society.

14 THE CHAIRMAN: More relevant to our  
15 enquiry, are you finding that there is any income group  
16 that the incidence of it is more in one income group  
17 than in another?

18 DR. RATHBURN: There was a report, sir,  
19 came from Ottawa, the Department of Statistics had been  
20 studying our figures and interestingly enough the  
21 tendency for these to occur in the lower income groups  
22 has not been as striking as was anticipated, and at the  
23 moment I don't think our figures are statistically  
24 sound yet, but it is not as marked as you might expect  
25 sir.

26 DR. BRAY: I think the public generally  
27 have become a little complacent regarding this idea,  
28 if you take vitamin drops you are covered, but this is  
29 probably not proven, but it is suggested at least that  
30 this is not the case. It is necessary to give orange  
juice and other things.

THE CHAIRMAN: You mean we cannot believe





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4 everything we see on the T.V. that if we buy one pill  
it will give us everything?

5 DR. BRAY: That is right.

6 COMMISSIONER FIRESTONE: To continue,  
7 Dr. Rathburn, would you say that there are many children  
8 that you examine with dietary deficiencies? Would that  
9 be one of the basic causes?

10 DR. RATHBURN: I think sir this depends  
11 on degree. The answer must be extraordinarily guarded.  
12 A survey I recall at John Hopkins University done on  
13 American children some ten years ago showed rickets in  
14 approximately 60% of all children examined, but this  
15 was microscopic record, not gross clinical defects,  
16 and I would hazard a wild guess that we are seeing some  
17 deficiencies in some 30% of our children, again based  
18 on the lack of public awareness of good nutrition, and  
19 this I think delves into our physical fitness programmes.

20 COMMISSIONER FIRESTONE: These dietary  
21 deficiencies, would they be in part due to the inability  
22 on the part of some parents to provide the children with  
23 adequate diets that provide them with adequate quantities  
24 of milk, or oranges? What are some of the reasons that  
25 we have these dietary deficiencies?

26 DR. RATHBURN: As I pointed out, the  
27 statistics are not showing this falls into an economic  
28 group. Therefore, the obvious answer is that it becomes  
29 a matter of public complacency on the problem of good  
30 dietary needs. I think it would be fair to say that  
in the paediatric patient group, the group of children  
who are under the care of paediatricians, who are shall







Rathburn

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4 we say ultra-conscious of diet and diet deficiency, who  
5 instruct their mothers every month about what they  
6 should feed them, I would doubt we see it in paediatricians'  
7 practice, but in the practice of general practitioners,  
8 who are not interested in children, and everybody isn't.  
9 I would suggest we see it in the other 12% of patients  
10 who never go to see a doctor unless something goes  
11 wrong, and here we must reach these by approaching the  
12 school medical programmes and drilling it into the  
13 children at school and on the television.

14 COMMISSIONER FIRESTONE: Are you suggesting  
15 that one of the basic approaches is increased education  
16 at the school level and at the parent level?

17 DR. RATHBURN: And also at the physician  
18 level.

19 COMMISSIONER FIRESTONE: Those are the  
20 three levels, physician, school and parent. Now, would  
21 you feel in addition to education such things as free  
22 school milk might help improve the dietary habits of  
23 the young?

24 DR. RATHBURN: Mr. Chairman, I am not  
25 sure I can personally answer this. Such programmes have  
26 been in existence even in my own community of London,  
27 Ontario, which is economically reasonably well off, and  
28 I think this is rather carrying coals to Newcastle. It  
29 can possibly be better spent. In Newfoundland there has  
30 been a programme to provide orange juice for the children,  
and as I pointed out cases of scurvy are still occurring  
there, and one questions sometimes whether they get  
whatever is distributed. The moment you make something







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4 compulsory, rather than make people want to do it, I  
5 think you are in trouble, and there is always a group  
6 who will rebel against compulsion and will not do it.

7 COMMISSIONER FIRESTONE: Instead of  
8 compelling to drink milk, but by providing it and  
9 setting an example, probably the majority of children  
10 would avail themselves of these possibilities. Would  
11 you then not feel that this would help to improve the  
12 diet, and it could be supplemented if you wished by  
13 making available certain basic vitamins?

14 DR. RATHBURN: This is one approach.  
15 The only counter-indication to that is one that the  
16 Food and Drug Committee have long held, and that is  
17 that really this is not solving the problem. You then  
18 have them protected as long as they are getting this  
19 particular whatever it is, and as soon as they get out  
20 of that age group, then they haven't been taught to  
21 eat the right foods, and they are going to become  
22 vitamin deficient when they are adults.

23 COMMISSIONER FIRESTONE: Well, I  
24 haven't suggested that this school programme of free  
25 milk and vitamins should replace the education programme.  
26 I am just asking you whether there is something else  
27 besides education that can be done, and whether you can  
28 suggest anything in that regard?

29 DR. DENTON: Mr. Chairman and Mr.  
30 Firestone, I think that Mr. Firestone has implied this  
is not a problem which can be answered by any single  
programme, whether it be one of education or provision  
of deficiencies, compensation of deficiencies by provision,





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but I think I must agree that purely the passive provision is a very short range corrective measure, but the long term has to be first in the understanding of the parents, and secondly of the school child, who will ultimately be the parent, of the nutrition needs for life and in a generation by providing suitable education methods supplementary provision would no longer be necessary.

COMMISSIONER BALTZAN: Just one thing too, perhaps in covering this thing that has started about vitamins. How sure are you of the vitamin content of some of the oranges and fruit and juices that you get? They may be drinking a lot and getting very little vitamins. Is there any control?

DR. RATHBURN: As to specific quantities, these can be readily analyzed, and I quite accept sir a variation from batch to batch, but studies at the hospitals for sick children and in the Food and Drug Division in Ottawa itself have produced fairly reliable figures for this, that I think are remarkably constant, give or take ten or fifteen per cent.

COMMISSIONER FIRESTONE: Would your Association be in favour of compulsory medical examination in schools, carried on by the medical profession in co-operation with school boards, the medical profession including of course your specialists?

DR. RATHBURN: Mr. Firestone and Mr. Chairman, I don't think there is any doubt our Association feels extremely strongly that all school children should be examined, and I think I might go







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3 further, and say that they should be examined by  
4 paediatricians. I think this would be an excellent way  
5 to spend a paediatrician's time.

6 COMMISSIONER FIRESTONE: That is a very  
7 forthright answer, and we are grateful to you.

8 My last question concerns the possible  
9 introduction of a national medical care insurance plan,  
10 which would provide that the Federal Government might  
11 contribute to provincial plans a certain proportion  
12 of costs, similar to what is now in operation under  
13 the hospital insurance plan. Let us assume that such  
14 a plan were to come into operation, and the provinces  
15 would administer and work out the terms in co-operation  
16 with the medical profession, including specialists such  
17 as yours. If such a plan were worked out, would you  
18 agree to co-operate with such a plan in the provinces  
19 where such a plan has been put into effect?

20 DR. RATHBURN: Mr. Firestone and Mr.  
21 Chairman, this cuts across many provinces, and obviously  
22 I foresee various difficulties in various areas. I  
23 have been across the country and discussed this very  
24 thing. Opinion is not unanimous. I think as a general  
25 rule most paediatricians feel that it seems to be the  
26 general feeling of the public that some insurance scheme  
27 is coming, and if this is what they wish, I think I  
28 speak for most of us that we feel that we should go  
29 along with it. We, as far as economics, as I say this  
30 is not our field, we will go with the C.M.A.

COMMISSIONER FIRESTONE: This is a very  
enlightened answer sir. Thank you very much.







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4 THE CHAIRMAN: Thank you very much Dr.  
5 Rathburn and gentlemen. You have been very helpful to  
6 us, and as you may know we have a Medical Education  
7 programme under Dr. MacFarlane. It is going into  
8 medical education in depth, and your submission and  
9 what has transpired here today will go to that Committee  
as well, so thank you very much.

10 Now we will have the submission from  
11 the Canadian Neurological Society.

12 ---EXHIBIT NO. 224:  
13

Submission of the  
Canadian Neurological  
Society.

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SUBMISSION OF  
THE CANADIAN NEUROLOGICAL SOCIETY

APPEARANCES: Dr. N.S. Keith  
Dr. C. Bertrand  
Dr. P. Robb  
Dr. M. Saunders

DR. ROBB: Mr. Chairman, may I have the pleasure of introducing my colleagues. On my extreme right Dr. William Keith, Associate Professor of Surgery, University of Toronto, Chief Neuro-Surgeon at the Sick Children's and the Toronto Western Hospital, president of the Canadian Neurological Society. Dr. Bertrand, Assistant Professor of Surgery, University of Montreal, Neuro-Surgeon in Chief at the Notre Dame Hospital; Dr. Saunders, Director of Electroencephology Department, Winnipeg General Hospital.

With your permission, sir, I would like to start on page 11 of the brief, the methods of improving health services.

Health services, as related to patients with disorders of the nervous system, may be improved in the following ways:

1) Assistance in the establishment of neurological and neurosurgical centres in cities and districts where the population density justifies it and where there are presently no such services.

2) Financial assistance for the provision of special equipment such as electroencephalographs, x-ray equipment, operating room, ward equipment, and special apparatus for clinical research in hospitals with the necessary trained personnel.







3) Improved facilities and financial support to out-patient clinics for the diagnosis and treatment of patients suffering from chronic disorders such as epilepsy, multiple sclerosis, cerebral palsy, Parkinsonism, etc.

4) Free drugs and appliances for the neurologically disabled where necessary.

5) The provision, and support of more facilities for the rehabilitation of inpatients and out-patients.

6) The provision of more beds for the care of the chronically ill and greatly expanded facilities for domiciliary care.

7) The support of clinical research to find means of preventing and improving treatment of injuries and diseases of the nervous system.

8) Provision of adequate facilities for basic research into the form, function, and diseases of the nervous system, including funds on a continuing basis where required.

At the present time there is a shortage of personnel in the neurological disciplines in Canada.

1) There are insufficient facilities for complete training in Canada.

2) The shortage of well trained men in the United States as well as the elaborate facilities for training and research, has resulted in the loss of many of our best candidates.

3) The need for more centres capable of training men in the basic sciences as well as the







clinical aspects of neurology, cannot be stressed enough.

4) Conditions should be improved so that we can develop and keep doctors of high standard to work and teach in these disciplines.

5) There should be adequate financial support for those wanting to follow a career in the basic neurological sciences and research.

METHODS OF PROVIDING ADEQUATE PERSONNEL WITH THE  
BEST POSSIBLE TRAINING AND QUALIFICATIONS FOR  
SUCH SERVICES

1) There must first be a high standard of teaching of basic neurological sciences, and clinical neurology at an undergraduate level.

2) Departments of neuroanatomy, neurophysiology, neuropathology, neurochemistry, virology, as well as neurology, and neurosurgery, should exist at all medical schools. Students should be encouraged in these sciences. There should be close co-operation with other departments of the medical schools and hospitals.

3) In order to carry out an adequate graduate training program there is an urgent need for full time staff both at a professional and fellowship level. This must be provided for in the budgets of universities and hospitals.

4) More bursaries should be available to enable trainees who are nearing completion of their training to travel to other centres or countries or to do additional work in basic sciences





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3 or research,

4 5) Training standards and requirements  
5 should be high, but sufficiently flexible to enable a  
6 trainee to become skilled in one particular aspect of  
7 neurology. For example, there is a need for more  
8 neurologists capable of working in paediatric neurology.

9 6) Financial support for the training  
10 of paramedical personnel particularly those who are  
11 likely to become teachers. This would apply to nurses,  
12 physiotherapists, occupational therapists, psychologists,  
13 and laboratory technicians.

14 Now, sir, could we read the summary at  
15 the beginning of the brief.

16 This brief presents a short picture of  
17 neurology and neurosurgery and the neurological sciences  
18 in Canada. Some of the existing facilities are dis-  
19 cussed. Many problems are reviewed, and some aspira-  
20 tions for future development in patient care and research  
21 are presented.

22 The main recommendations are:

23 1) More and better facilities for the  
24 care of the neurologically disabled to include:

25 a) The establishment of additional  
26 centres, and increasing facilities  
27 on the basis of one neurologist per  
28 60,000 persons and two neurosurgeons  
29 for every 250,000 persons.

30 b) The provision of more beds for the  
chronically ill.

c) Better facilities and support for







Robb

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neurological investigation on an  
outpatient basis.

d) More facilities for rehabilitation.

2) Complete centres at each medical  
school, including departments in all basic sciences  
related to the nervous system, as well as ancillary  
services. Besides providing the best in medical care  
for patients and training facilities for medical students,  
such centres will train neurologists, neurosurgeons,  
scientists in allied fields, and paramedical personnel.

3) Greatly increased support and better  
integration of basic and clinical research on the  
nervous system both on a temporary and a continuing  
basis.

THE CHAIRMAN: Thank you very much,  
Dr. Robb. Dr. Baltzan?

COMMISSIONER BALTZAN: I appreciated  
the brief very much. I have read it and I have prepared  
no specific questions.

THE CHAIRMAN: Dr. Strachan? Dr. Van  
Wart?

COMMISSIONER VAN WART: On page 4 you  
speak of the development of more departments. The  
question arises is the personnel for teaching in these  
departments available if they were established?

DR. ROBB: The personnel is not available  
at the present. This is part of the brief. We have  
trained a great many men. Due to the attraction below  
the border we lose them as fast as we train them. If  
we had the facilities and were able to provide them with







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4 the type of research facilities and support them  
5 financially in early years these personnel would be  
6 available.

7 COMMISSIONER VAN WART: That would be  
8 in sufficient numbers to man these departments which  
9 you are suggesting be established?

10 DR. ROBB: Yes.

11 COMMISSIONER VAN WART: On page 13 you  
12 state there are insufficient facilities for complete  
13 training in Canada. You don't have these departments  
14 at the present time and you say under financial contri-  
15 butions and so on, et cetera, you would be able to get  
16 enough people to be able to man these new departments.  
17 You make the statement there are insufficient facilities  
18 for the training or teaching of these people. I cannot  
19 recognize the availability of staff when you don't have  
20 the facilities to teach here in the country at the  
21 present time.

22 DR. ROBB: In Canada there are facilities  
23 for completely training the neuro-surgeon or neurologist  
24 in Montreal and in Toronto, limited facilities in the  
25 other provinces, but I feel and I believe the other  
26 members would agree with me, these are the only two centres  
27 where a man can receive complete training without going  
28 elsewhere.

29 Some of the universities haven't  
30 departments of neurology or neurosurgery. They haven't  
the basic sciences. In Prince Edward Island, for  
example, there are no neurologists or neurosurgeons.  
In New Brunswick there is one neurosurgeon and no  
neurologists. In Halifax they have neurologists and





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Robb

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neurosurgeons, but no facilities for complete training.  
It is similar across Canada.

COMMISSIONER VAN WART: Thank you.

THE CHAIRMAN: Miss Girard?

COMMISSIONER GIRARD: I want to make a comment, to say I am happy you gentlemen have put in your brief a mention of nurses in relation to bursaries. We in the nursing profession are very short of nurses well prepared to second the neurosurgeon in the neurological field, and we would very much like to have more nurses that would be prepared to do this kind of work.

DR. ROBB: That is very kind of you to say this. I might refer you to page 2 of the brief where we mention the teamwork necessary in the care of the patients who are suffering from neurological, neurosurgical disorders. The nurse is one of the most important members of the team and is somebody who we appreciate very much.

COMMISSIONER GIRARD: One of the important members of the team if she is well prepared, would you agree? I think in all cases you might be happy to have a nurse on the team, but we feel nurses must be prepared particularly to second the physician well in this field. I am sure you have experience at times where you have a case and call the registry for a special nurse and a great number of nurses will refuse to take the case because they are not specialists in the field. They are afraid. If they don't know enough about it they are rightly afraid. This is a field







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4 where a nurse should be trained. She should have some  
5 post-graduate training or, at least, have some experience  
6 in order to be able to second you well.

7 DR. ROBB: I would certainly agree with  
8 this, and point out we are somewhat disappointed at the  
9 Montreal Neurological Institute that so many of the  
10 nurses who come for post-graduate training are coming  
11 from places other than Canada, from all over the world,  
12 while there are insufficient bursaries in Canada to  
13 send nurses to centres such as Toronto and Montreal for  
14 post-graduate training in this field.

15 COMMISSIONER GIRARD: That is right.

16 COMMISSIONER FIRESTONE: Dr. Robb, on  
17 page 12 in paragraph 2 you recommend financial  
18 assistance for the provision of special equipment, and  
19 you elaborate on the type of equipment you have in  
20 mind. Could you explain to us what financial assistance  
21 you are recommending?

22 DR. ROBB: I will refer that to Dr.  
23 Saunders.

24 DR. SAUNDERS: This, I think, sir, is  
25 the purpose of new equipment for new procedures that  
26 are being developed every year, and also a difficult  
27 problem has arisen with the hospital services that the  
28 coverage of this type of equipment is depreciated on a  
29 16-year basis whereas in the field I am interested in,  
30 electroencephlogy the equipment is almost useless at the  
end of a 5-year period. This means the money has to  
come from somewhere to either renew the equipment or  
substitute equipment, and this money is only coming out







Robb

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3 of the depreciation for the boilers that have been put  
4 in, and things of that sort. The definition of the  
5 source of the financial assistance isn't stated. It is  
6 a very necessary point, though.

7 COMMISSIONER FIRESTONE: Would you  
8 visualize it, sir, this would be a federal health grant  
9 made to provinces to help in deferring the cost of this  
10 equipment? Is that what you had in mind?

11 DR. ROBB: The present scheme of  
12 Federal-Provincial grants which has existed to the  
13 present has been most helpful. The equipment is  
14 extremely expensive, and we as a group are greatly  
15 concerned about our ability to maintain the standards  
16 of equipment under the present 16-year depreciation  
17 scheme. Unless it is altered it is going to lead to  
deterioration in medical care.

18 COMMISSIONER FIRESTONE: In other words  
19 you feel the present system, while helpful, hasn't  
20 been fully adequate, and you therefore recommend  
21 increased grants to take care of the increasing  
22 obsolescence of your equipment? Is that your recommenda-

23 DR. ROBB: Yes, and further that such  
24 aid be available in the development of new centres.

25 DR. SAUNDERS: I think there is another  
26 point: We should have moneys available for the purchase  
27 of new equipment as new tests become available. At  
28 the moment there is no source beyond either benevolent  
29 societies, occasionally from industries or individual  
30 gifts from kind donars. Within the next ten years there





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3 are going to very, very many changes and much more  
4 equipment is going to be used.

5 COMMISSIONER FIRESTONE: Who purchases  
6 that equipment.

7 DR. SAUNDERS: At the moment this  
8 equipment is being purchased by foundations, being  
9 purchased by companies and not through any governmental  
10 source at all.

11 THE CHAIRMAN: Do the practitioners  
12 purchase the equipment?

13 DR. SAUNDERS: No, well, not always.  
14 Occasionally we will get a practitioner giving a gift  
15 to an institution out of his own pocket. Some of the  
16 medical societies will sometimes give money towards it.

17 THE CHAIRMAN: You were speaking of  
18 this being depreciated over a 16-year period, institutionally,  
19 that is in the hospital?

20 DR. SAUNDERS: That is in the hospital,  
21 sir, but the hospitals are requiring extra money for  
22 purchasing of completely new types of equipment.

23 COMMISSIONER FIRESTONE: Would you not  
24 feel this should be on a business-like basis so you  
25 wouldn't have to depend on charity to buy new equipment  
26 when you need it?

27 DR. SAUNDERS: I think it should be on  
28 this basis.

29 COMMISSIONER FIRESTONE: Therefore your  
30 recommendation is it should be covered by State grants,  
and these grants being adequate enough to acquire the  
equipment when you need it and not having to go and ask







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4 people to be kind enough to provide the equipment,  
5 otherwise you couldn't give your patients the new  
6 treatments that become available?

7 DR. SAUNDERS: That is right.

8 DR. ROBB: Could we ask Dr. Bertrand  
9 to comment on this. He is doing marvellous work in  
10 research in the treatment of Parkinsonism.

11 DR. BERTRAND: We have experience in  
12 that field two ways, first, through the neurological  
13 institute, in starting new, setting up, where there  
14 was no neurosurgery departments, not only is personnel  
15 a problem, nurses, but of getting basic equipment. At  
16 the present time there are no funds available and it  
17 is a great temptation to go south of the border where  
18 such facilities are available. Secondly if you do  
19 develop a new technique the initial equipment has to be  
20 paid for personally, even the initial research until  
21 it is proven that something will come out of it. Until  
22 you can prove your point you have to supply funds or  
23 get it from private sources, which is not always easy.  
24 Thirdly, once the research is on the way you have to submit  
25 your research plan, especially clinical research a year  
26 ahead of time. By the time you get the funds part of  
27 the equipment required may not be necessary and other  
28 facilities such as cathode ray oscilloscopes or special  
29 apparatus, you may not have available, so that there  
30 is a long pull. There is a period in which time is  
lost and the necessary equipment is not available. I  
believe that the money should be readily available if  
need is proven to be there, and be available without loss







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3 of time in the proper institutions.

4 I think especially if you want to  
5 create new centres problems will arise, and if these  
6 people have original ideas and they want to bring them  
7 up they will find it very difficult to find under the  
8 present system the funds which they need. South of  
9 the border they may have gone overboard and sometimes  
10 money is too readily available, but certainly that is  
11 not the case here. We need to go far ahead in clinical  
12 research, especially. If you are not in pure research  
13 it is a difficult situation.

14 COMMISSIONER BALTZAN: You speak of the  
15 present system, you mean the system invoked since the  
16 new scheme of hospital financing?

17 DR. BERTRAND: I am sorry, no, I mean  
18 the present system in Canada before health insurance and  
19 also since health insurance, because there is very  
20 little, especially for clinical research in the present  
21 health insurance scheme. There is no provision for  
22 clinical research aids. There is no provision in the  
23 present scheme in the Province of Quebec for research  
24 funds. There is with the federal mental -- federal  
25 health programme, but these funds are not available  
26 readily.

27 /PM/hm COMMISSIONER BALTZAN: Would you say  
28 you are better or worse off under the current system  
29 than you were before or is there any difference?

30 DR. BERTRAND: You mean in the Province  
of Quebec?

COMMISSIONER BALTZAN: Yes.





Robb

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4 DR. BERTRAND: As Dr. Robb has pointed  
5 out because of this depreciation system I think we are  
6 worse off because the hospital is not at liberty to  
7 purchase equipment where otherwise if you can find the  
8 money you could purchase it but now you cannot.

9 COMMISSIONER BALTZAN: You can't go out  
10 and have the same sort of appeal as before?

11 DR. BERTRAND: It is pretty difficult  
12 to make an appeal to a private source when they know  
13 that the government is financing the hospital. They  
14 will say they are paying taxes for that and are not  
15 going to give money to the government.

16 COMMISSIONER FIRESTONE: On the point  
17 you made a little earlier that you find it difficult  
18 to get funds from the Federal Government to start  
19 research in your specialized field, can you tell us  
20 what some of those difficulties are?

21 DR. BERTRAND: Well, I mean it is not  
22 difficult once you have established that the need is  
23 there, but it is difficult to get started. If we are  
24 going to start new centres I believe those funds should  
25 be available for the basic equipment.

26 COMMISSIONER FIRESTONE: I am trying to  
27 understand the point you are making, is it the difficulty  
28 that you get research funds once the research programme  
29 is established but it is difficult to get the funds  
30 when you are establishing a research programme? Is  
that the point?

DR. BERTRAND: Yes. When you start a  
programme it is difficult because you do not know exactly







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4 where that programme will take you, you do not know  
5 whether you will need certain equipment or not and you  
6 have to make a plan a year ahead, submit your proposal  
7 to get your funds and you start on the programme and  
8 find you need something else and have to wait another  
9 year for some of the equipment. Secondly, I would  
10 suggest more long term funds rather than short term a  
11 year at a time. If there was a research fund which is  
12 provided for five or ten years you could go ahead knowing  
13 that the fund will be coming to you year after year.

14 COMMISSIONER FIRESTONE: Do you know  
15 of cases where research funds have been refused by the  
16 Department of National Health and Welfare where in the  
17 opinion of professional people this was a worthwhile  
18 and instructive research proposal?

19 DR. BERTRAND: No, I do not know of any  
20 incident where it was worthwhile research. I know when  
21 you start in the field it is difficult to know where to  
22 go for the right application and how to get the necessary  
23 funds for the plan.

24 COMMISSIONER FIRESTONE: And the diffi-  
25 culty is because people do not know how to go about it  
26 or because Ottawa does not co-operate with the people  
27 who want to go ahead?

28 DR. BERTRAND: I do not know about  
29 Ottawa not co-operating because in our case they have  
30 co-operated very well. I believe, first of all, people  
do not know, it is difficult to establish where to  
pinpoint your project; does it come under health or under  
the National Research Council or is it purely a matter of







Robb

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4 biostatistics. It is hard to know and they throw the  
5 ball from one to another and in our specialty the ball  
6 may come through mental health, public health to the  
7 National Research Council and if you have a plan that  
8 is partly research and partly clinical you have to  
9 convince them. It is a great problem.

10 COMMISSIONER FIRESTONE: You have made  
11 an instructive suggestion that we have not heard until  
12 now that some of these research plans should cover a  
13 longer period of time to assure continuity of the  
14 programme and possibly also achieve the one point that  
15 Dr. Robb had in mind to keep more Canadian<sup>s</sup> doing research  
16 in Canada; is that what you had in mind?

17 DR. ROBB: Yes, this is very important.

18 DR. KEITH: It is the matter of continuing  
19 grants, the three or five-year term was thoroughly  
20 discussed by us and we were unanimous about it.

21 COMMISSIONER FIRESTONE: It is a con-  
22 structive proposal and we are very much obliged to you  
23 for making it to us. May I turn to paragraph 3 on the  
24 same page where you say you are in favour of improved  
25 facilities and financial support to out-patient clinics  
26 for the diagnosis and treatment of patients suffering  
27 from chronic disorders. Then you give some examples.  
28 Are you aware under the hospital insurance plan provision  
29 is made by the province to obtain some of the financing  
30 from the Federal Government for the operations of out-  
patient clinics? Are you familiar with this provision?

DR. ROBB: These provisions are not  
available in Quebec.





Robb

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THE CHAIRMAN: At least not yet?

DR. ROBB: Well, we are presenting this brief as to the existing facilities. This is a very critical point, we feel very strongly because it not only effects the out-patients who urgently need care but most of these neurological disorder patients are indigent in that they cannot support themselves and, therefore, they need financial support. We are anxious to see that they get the best of medical care but also it is true that if these patients can be investigated on an out-patient basis our hospital beds will not be as crowded.

COMMISSIONER FIRESTONE: I take it the implication of your paragraph 3 is a recommendation that the existing provisions that are opened up the possibility for the province to make use of close to 50% sharing by the Federal Government in the case of these out-patient clinics should be met in the Province of Quebec, is that the recommendation?

DR. ROBB: Yes.

COMMISSIONER FIRESTONE: Paragraph 4 on the same page you say that you recommend:

"Free drugs and appliances for the

"neurologically disabled where necessary".

Can you please define the phrase "where necessary"?

DR. ROBB: Yes, those patients who are attending clinic are required to pay out large amounts of money over a long term basis and most of them are indigent. On the other hand, and there are many patients who we are treating who are self-supporting, they are not indigent and they are quite capable and anxious and



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Robb

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4 willing to pay for their own drugs and their own  
5 appliances be it a wheel-chair or orthopaedic appliances  
6 or whatever it is.

7 COMMISSIONER FIRESTONE: "Where necessary"  
8 then refers to free drugs and other equipment to the  
9 indigent?

10 DR. ROBB: Yes.

11 COMMISSIONER FIRESTONE: Would that also  
12 include what we call the medically indigent, people  
13 that may not be welfare cases, have a low income inadequate  
14 to pay the heavy financial burden involved. Would you  
15 extend it to that group as well?

16 DR. ROBB: Yes, this partially exists  
17 at present. I am sure, in defence of the present scheme,  
18 it is possible to get 50% of the cost of an appliance  
19 paid for if one knows the right channels but it is not  
20 possible for drugs.

21 COMMISSIONER FIRESTONE: What are the  
22 right channels?

23 DR. ROBB: One has to apply through a  
24 welfare agency to the government for help.

25 COMMISSIONER FIRESTONE: And I take it  
26 the answer to my question that this proposal covers both  
27 the indigent and medically indigent is "yes"?

28 DR. ROBB: Yes.

29 COMMISSIONER FIRESTONE: Could I now  
30 turn to paragraph 5 on page 13 where you state:

"There should be adequate financial  
"support for those wanting to follow a  
"career in the basic neurological sciences  
"and research".

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appliances be it a wheel-chair or orthopaedic appliances

COMMISSIONER WESTON: "Where necessary"

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welfare agency to the Government for help.

COMMISSIONER WESTON: And I take it

the answer to my question that this proposal covers both  
the indigent and medically indigent is "yes?"

COMMISSIONER WESTON: Could I now

turn to paragraph 5 on page 13 where you state:

"There should be separate financial

support for those waiting to follow a

career in the basic nonmedical sciences

"and research."





Robb

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4 Do you have in mind a system of graduate  
5 scholarships?

6 DR. ROBB: Yes.

7 COMMISSIONER FIRESTONE: Could you tell  
8 us what amount you would consider appropriate as a  
9 graduate scholarship if people want to take up this  
10 particular specialty of yours?

11 DR. ROBB: Yes. If I might preface  
12 that by one remark; one reason for it is at the Montreal  
13 Neurological Institute where some of the men attempting to  
14 do this work have to spend time seeing patients on a  
15 private basis in order to try to make a living. I  
16 would think that fellowships from \$7,000.00 to \$10,000.00  
17 would be quite sufficient to attract men into this  
18 basic science and as they develop and become teachers  
19 and professors there would be an increase in their  
20 remunerations.

21 COMMISSIONER FIRESTONE: And now, this  
22 is very helpful. How many such scholarships or fellow-  
23 ships would you visualize in Canada to get a sufficient  
24 number of people in Canada and develop more specialists  
25 in your field?

26 DR. ROBB: I would be guessing if I  
27 tried to answer that question. We would have to  
28 analyze it in the terms of the number of universities  
29 and the number of departments in each university.

30 COMMISSIONER FIRESTONE: You realize that  
while we do not want you to do any guessing whatsoever,  
what we really need is your best judgment if this  
Commission has to make any recommendation to the  
Canadian Government. We would like to have advice from



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Dr. Ross: Yes.

COMMITTEE: Could you tell

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particular specialty of yours?

Dr. Ross: Yes. If I might propose

that by one remark; one reason for it is at the Montreal  
Neurological Institute where some of us are attempting to  
do this work have to spend the evening patients on a  
private basis in order to try to make a living. I

would think that fellowships from \$5,000.00 to \$10,000.00  
would be quite sufficient to attract men into this  
kind of science and as they do stop and become teachers  
and professors there would be an increase in their

number.

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number of people in Canada and develop more specialists  
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Robb

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4 the professions and presumably you must have some idea  
5 of what you would do in terms of five or ten a year  
6 or 30 or 50 a year? What would you consider realistic  
7 assuming some people can look after their own graduate  
8 studies but you want to get a number of men a year and  
9 you must make a start somewhere, somehow.

10 DR. ROBB: I would refer to the Montreal  
11 Neurological Institute where we have 30 Fellows  
12 approximately doing this type of research work and  
13 supported in different ways. If there were ten, let  
14 us say there were six complete units in Canada one  
15 would have 120 research Fellows of this type.

16 DR. KEITH: I think the Montreal  
17 Neurological Institute has a very high number of research  
18 Fellows compared to any other institution in Canada  
19 and I would suggest 15 as a start.

20 DR. SAUNDERS: I was going to guess at  
21 twenty.

22 COMMISSIONER FIRESTONE: It would be  
23 something of the order of 15 or 20?

24 DR. SAUNDERS: I would like to say that  
25 is basic neurological sciences and research, not  
26 neurology and neurosurgery.

27 COMMISSIONER FIRESTONE: That is very  
28 helpful and a positive way of guiding us and we are very  
29 grateful to you. There is one more question on finance,  
30 page 15 paragraph 6 where you offer the suggestion that  
financial support should be given for the training of  
paramedical personnel, those who want to become teachers.  
What kind of financial support do you have in mind,  
again, scholarships, bursaries?







Robb

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DR. ROBB: Scholarships particularly.

I had a great deal of work in the field of cerebral palsy and I am always looking for money to send doctors on my staff away for further training. We pick members of the staff but where people have a good choice in terms of staying with us or moving someplace else where they will teach and spread the gospel.

COMMISSIONER FIRESTONE: What amounts would you have in mind for this type of scholarship or bursary per year?

DR. ROBB: Between \$2,400.00 and \$4,000.00 depending on the qualifications of the particular person.

COMMISSIONER FIRESTONE: And how many such scholarships or fellowships would you feel would be desirable as a start? You have to begin somewhere?

DR. ROBB: I would say 20.

COMMISSIONER FIRESTONE: My last question is a question you heard me ask the Canadian Paediatric Association and if I may restate it; Dr. Robb, should there be developed in Canada a national medical care insurance plan whereby the Federal Government may make a contribution of up to 50% of provincially operated plans, plans that are developed in each province in co-operation and consent with the medical profession and such a plan would be somewhat similar to the hospital insurance plan and the co-operation that exists under the plan, would you say that the Canadian Neurological Society would support such a plan and co-operate under such a plan?







Robb

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4 DR. ROBB: Provided that the medical  
5 profession had an opportunity to participate in the  
6 direction of such a plan. I for one, speaking personally,  
7 would co-operate and I believe members of the Canadian  
8 Neurological Society would do the same.

9 COMMISSIONER FIRESTONE: Thank you, that  
10 is a very enlightened answer.

11 THE CHAIRMAN: Thank you very much,  
12 gentlemen. As I mentioned to the delegation who were  
13 here before you, all these briefs deal with specialties  
14 and particularly in the field of medical education and  
15 they are going to receive their attention under the  
16 project of Dr. MacFarlane and his associates. Besides  
17 having the attention of the Commission your brief will  
18 receive the consideration of that special project  
19 committee as well. Thank you.

20 DR. ROBB: May I on, behalf of my  
21 colleagues and myself, thank you for the privilege of  
22 appearing before you.

23 THE CHAIRMAN: The next submission will  
24 be from the Association of Obstetricians and Gynaecologists  
25 of the Province of Quebec and the submission will be  
26 exhibit number 225; the french version will be exhibit  
27 225A.

28 ---EXHIBIT NO. 225:

Submission of Association  
of Obstetricians and  
Gynaecologists of the  
Province of Quebec.

29 ---EXHIBIT NO. 225A:

Submission of Association  
of Obstetricians and  
Gynaecologists of the  
Province of Quebec,  
french version.



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Commission had an opportunity to participate in the  
direction of such a plan. I for one speaking personally  
would co-operate and I believe members of the Canadian  
Neurological Society would do the same.

COMMISSIONER FISHBURN: Thank you, that

is a very well-phrased answer.

THE CHAIRMAN: Thank you very much.

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here before you, all these matters deal with specialists  
and particularly in the field of medical education and  
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colleagues and myself, thank you for the privilege of  
appearing before you.

THE CHAIRMAN: The next session will

be from the Association of Obstetricians and Gynecologists  
of the Province of Quebec and the session will be  
at this number 125; the French version will be exhibit

Association of Obstetricians and Gynecologists  
of the Province of Quebec

EXHIBIT NO. 125

Association of Obstetricians and Gynecologists  
of the Province of Quebec

EXHIBIT NO. 125



SUBMISSION OF  
THE ASSOCIATION OF OBSTETRICIANS AND GYNAECOLOGISTS  
OF THE PROVINCE OF QUEBEC

APPEARANCES:

Dr. F.J. Tweedie  
Dr. G. Maughan  
Dr. Vadeboncoeur  
Dr. R. Lapointe  
Dr. F. X. Demers

DR. TWEEDIE: Mr. Chairman and members of the Commission; may I first present my colleagues and our delegation. On my right Dr. F.X. Demers; next to him is Dr. Roger Lapointe. On my left is Dr. George Maughan and also Dr. Vadeboncoeur and I am Dr. F. J. Tweedie.

With your permission, sir, I will now proceed with the reading of the summary of our brief, which may be found on page 13 of the English version, page 15 of the French version.

The population of the Province of Quebec has benefited along with the rest of Canada from the remarkable improvements in obstetrical and gynaecological care which have been manifest in the past 25 years. This limited period has witnessed a tenfold decrease in maternal mortality, a twofold decrease in perinatal mortality, a marked reduction in risk and morbidity relative to childbirth and gynaecological surgery, and a progressive improvement in the cure rate of uterine malignancy, spearheaded by the discovery and wide clinical application of cytological cancer detection techniques.







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4 However, it must be admitted that the  
5 statistical record of obstetrical performance in the  
6 Province of Quebec is poor in comparison with most other  
7 provinces in Canada. While it would be convenient to  
8 attribute this to geography, it is likely due to many  
9 factors, including the following:

- 10 (1) The relatively high percentage of home  
11 deliveries with their proven hazards.
- 12 (2) The lack of adequate hospital facilities  
13 and transportation to such facilities in  
14 certain areas (e.g. the lower St.  
15 Lawrence North shore).
- 16 (3) Inadequate facilities and consultative  
17 services in smaller hospitals.
- 18 (4) The unknown but suspect calibre of  
19 obstetrics practised in the small private  
20 hospitals.
- 21 (5) The inadequate numbers and maldistribu-  
22 tion of specialists and available con-  
23 sultative services, not compensated for  
24 by the provision of mobile units.
- 25 (6) Failure to use consultative services  
26 when such are readily available.
- 27 (7) The limited functions of the section of  
28 Maternal and Child Welfare of the pro-  
29 vincial government, and lack of liaison  
30 and rapport with the practising medical  
profession.

In the field of gynaecology, it is  
apparent that a large percentage of gynaecological







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4 operations in Quebec are still being performed by the  
5 general surgeon not certified in gynaecology. This is  
6 not confined to areas where specialists are either not  
7 represented or deficient in number, but also in large  
8 centres including Montreal, and in a significant number  
9 of hospitals of several hundred beds where there seems  
10 to be resistance to specialist intrusion on the part of  
11 those in charge. There is evidence to suggest that a  
12 significant percent of such operations was neither well  
13 indicated nor justified by the result.

14 Based on the foregoing, the following  
15 recommendations are submitted:

- 16 (1) That combined certification in Obstetrics and  
17 Gynaecology be approved and that discontinuance  
18 of separate certification in future be recommended  
19 to appropriate bodies. This, of course, is not  
20 meant to imply any change in status of certifica-  
21 tion already granted.
- 22 (2) That the detailed need of the province for  
23 additional specialists and consultative services,  
24 and for a more equitable and balanced distribu-  
25 tion of such services, be further studied.
- 26 (3) That a survey of existing resources and other  
27 ways and means to provide such additional  
28 services be made.
- 29 (4) That home deliveries with their proven hazards  
30 be eliminated as soon as possible by (1) public  
education, and (2) provision of proper hospital  
facilities where such are inadequate or non-  
existent.

operations in Quebec are still being performed by the general surgeon not certified in gynecology. This is not confined to areas where specialists are either not represented or deficient in number, but also in large centres including Montreal, and in a significant number of hospitals of several hundred beds where there seems to be resistance to specialist intervention on the part of those in charge. There is evidence to suggest that a significant percent of such operations was neither well indicated nor justified by the result.

Based on the foregoing, the following

recommendations are submitted:

- (1) That combined certification in Obstetrics and Gynecology be approved and that disqualification of separate certification in future be recommended to appropriate bodies. This, of course, is not meant to imply any change in status of certification.
- (2) That the detailed need of the province for additional specialist and consultative services and for a more equitable and balanced distribution of such services, be further studied.
- (3) That a survey of existing resources and other ways and means to provide such additional services be made.
- (4) That home deliveries with their proper hazards be eliminated as soon as possible by (1) public education, and (2) provision of proper hospital facilities where such are indicated and are not existent.



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3 (5) That adequate transportation services be provided  
4 where needed both for patients to hospital and  
5 for mobile units providing consultative service  
6 to outlying areas.

7 (6) That survey of private hospitals as for public  
8 hospitals along the lines of Hospital Accredita-  
9 tion be made mandatory as an essential qualifica-  
10 tion for hospitalization benefits in order to  
11 assure at least minimum standards of care and  
12 assess the need of controls, and that lists of  
13 accredited hospitals be published at periodic  
intervals.

14 (7) That a new era of liaison and co-operation  
15 between the specialty and the appropriate  
16 departments of government be instituted in an  
17 effort to improve the record of obstetrical  
18 and gynaecological practice in the province.  
19 This should have particular reference to:  
20 (a) further provision of special facilities for  
maternity and newborn care.  
21 (b) the specialized training of personnel.  
22 (c) public and professional education.  
23 (d) the assessment of statistics relative to  
24 maternal and perinatal mortality.  
25 (e) the initiation of province wide surveys of  
26 maternal and perinatal deaths.  
27 (f) the support of research in the area of  
maternal and child welfare.

28 In order to facilitate such co-operation, the  
29 specialty has recently formed a provincial Association of  
30



where needed both for patients to hospital and for mobile units providing consultative service to outlying areas.

(6) That survey of private hospitals as for public hospitals along the lines of Hospital Accreditation be made mandatory as an essential condition for hospitalization benefits in order to assure at least minimum standards of care and assess the need of controls, and that lists of accredited hospitals be published at periodic intervals.

(7) That a new era of liaison and co-operation between the specialty and the appropriate departments of government be instituted in an effort to improve the record of obstetrical and gynaecological practice in the province. This should have particular reference to:

- (a) further provision of special facilities for maternity and newborn care.
- (b) the specialized training of personnel.
- (c) public and professional education.
- (d) the assessment of statistics relative to maternal and perinatal mortality.
- (e) the initiation of province-wide surveys of maternal and perinatal deaths.
- (f) the support of research in the area of maternal and child welfare.

In order to facilitate such co-operation, the specialty has recently formed a Provincial Association of



Tweedie

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4 Obstetricians and Gynaecologists and now stands prepared  
5 to consult and act with the Government and with other  
6 groups interested in maternal and child welfare with the  
7 objective of seeking solutions to outstanding problems  
8 and of improving performance and results in this, an  
important field of medicine.

9 THE CHAIRMAN: Thank you very much Dr.  
10 Tweedie. As with the other delegations which have  
11 appeared before us, we have occasion to put some questions  
12 to elucidate some of the ~~matters~~ which you have brought  
13 forward, and on page 15, number 6, the one you just  
14 read a few moments ago, where you refer to a survey  
15 of private hospitals as for public hospitals. What do  
16 you mean by the expression private hospitals in this  
context?

17 DR. TWEEDIE: Private hospitals are to --

18 THE CHAIRMAN: Do you mean proprietary  
19 hospitals, public hospitals and private hospitals, as  
20 talking to somebody who does not know the immediate  
21 situation? In my province we have no such thing as  
a private hospital in that sense Doctor.

22 DR. TWEEDIE: Well, a private hospital  
23 in Quebec as I understand it, is privately-owned and  
24 privately-run. It is not supported by public funds  
25 in any manner, and I think this is perhaps the essential  
26 differentiation.

27 THE CHAIRMAN: Does such a hospital  
28 qualify to receive payment under the Hospitalization  
Act?

29 DR. TWEEDIE: I believe some of them do.  
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Tweedie

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4 THE CHAIRMAN: Well now, is it of those  
5 which do or those which do not that you are talking  
6 about here?

7 DR. TWEEDIE: This is directed towards  
8 finding out more about standards of medical care, and  
9 in my opinion all hospitals, small or large, should  
10 be subject to some sort of survey. This is a survey  
11 to satisfy those who conduct it, and especially the  
12 medical profession who are responsible for providing  
13 medical care, that standards in these small hospitals  
14 reach a certain minimum level, and are maintained there,  
15 and at the present time hospital accreditation is a  
16 voluntary matter. It applies to hospitals over 25 beds,  
17 and as I understand it there is no particular survey  
18 or surveys on the smaller hospitals, and there is a  
19 considerable volume of obstetrics and gynaecology  
20 practised in these hospitals, and that is our special  
21 interest.

22 THE CHAIRMAN: The matter of these  
23 private hospitals is particularly within the jurisdiction  
24 of the local authority, of the province, but where the  
25 private hospital is on the list, or is amongst those  
26 which are on the list that receive the hospitalization  
27 grant, then because there is federal money involved in  
28 that grant, naturally it becomes quite relevant within  
29 our terms of reference to concern ourselves about those  
30 hospitals which are receiving federal moneys, and you  
say there are some which do receive the hospitalization  
grant, rather that is if the patient goes into one of  
those hospitals, that the patient's bill is paid as in the





Tweedie

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4 case of a general hospital, as in the case of a public  
5 hospital, and some if the patient goes in there he or  
6 she pays the whole bill, without reference at all to the  
7 hospitalization programme, is that right?

8 DR. LAPOINTE: I think you are right.  
9 There is a large number of small private hospitals  
10 which are subsidized at present by the government, and  
11 on the other hand there are also small hospitals that  
12 are not subsidized by the government, but what we  
13 wanted to point out in our brief was that there are  
14 perhaps too many of these hospitals where there is no  
15 medical supervision, where obstetrics is performed  
16 perhaps in an inadequate way, so that we request in our  
17 brief that these small hospitals should be supervised  
18 more effectively by specialists, and that these  
19 hospitals should require consultants, it should be  
20 required of these hospitals that consultants should be  
21 attached to these hospitals.

22 THE CHAIRMAN: Have you made such a  
23 request to the Quebec Government?

24 DR. LAPOINTE: Not yet.

25 THE CHAIRMAN: As I was saying, these  
26 hospitals are under the jurisdiction of the province.

27 DR. LAPOINTE: That is quite correct.  
28 It is our intention to do so within a short time.

29 THE CHAIRMAN: Where a hospital does  
30 ~~qualify~~ to receive the hospitalization payments, that  
is to have the bills of patients paid under the  
hospitalization scheme, is there not some form of  
inspection at the present time?







Tweedie

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4 DR. TWEEDIE: Inspection as far as  
5 medical standards are concerned ---

6 THE CHAIRMAN: No, inspection in some  
7 form so as to qualify to come on the list, or is it  
8 purely ---

9 DR. TWEEDIE: The qualification I think  
10 that perhaps is most used is that 40% of the beds are  
11 classified as standard ward care. I know of no  
12 accredited body that goes to these hospitals to see that  
13 a certain minimum standard of medical care is met.

14 I would ask Dr. Maughan if he knows of  
15 any...

16 DR. MAUGHAN: I don't believe there is  
17 anybody goes to them to survey their medical care at  
18 all.

19 THE CHAIRMAN: Well, I take it that this  
20 is something that you regard as of some considerable  
21 importance?

22 DR. TWEEDIE: Very much so.

23 DR. MAUGHAN: Mr. Hall, I feel that it  
24 is of particular importance, because most of these  
25 small hospitals will do a lot of obstetrical work, and  
26 very little general medical work. They feel that they  
27 can be nursing homes for obstetrical care, and will do  
28 very little general medical care, and certainly very  
29 little general surgical care.

30 THE CHAIRMAN: In these hospitals the  
patients go and pay their own way?

DR. MAUGHAN: I am not positive of the  
answer to that question. It is my understanding that a

medical standards and standards --

THE CHAIRMAN: No, inspection is some

form so as to qualify to come on the list, or is it

purely ---

MR. TWEED: The qualification I think

that perhaps is most used is that 90% of the beds are

classified as standard ward care, I know of no

accredited body that goes to these hospitals to see that

a certain minimum standard of medical care is met.

I would ask Dr. Marshall if he knows of

MR. TWEED: I don't believe there is

anybody else to whom we know their medical care at

THE CHAIRMAN: Well, I take it that this

is something that you have heard of some countries

reporting

MR. TWEED: Very much so.

MR. TWEED: No, I feel that it

is of particular importance, because most of these

small hospitals will do a lot of obstetrical work, and

very little general medical work. They feel that they

can be nursing homes for obstetrical care, and will do

very little general medical care, and certainly very

little general surgical care.

MR. TWEED: In these hospitals the

patients are not on their own way?

MR. TWEED: I am not positive of the

answer to that question. It is my understanding that a





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3 large number of them are receiving funds under the Hospitali-  
4 zation Act. Certainly a large number in this city  
5 are so doing. Otherwise the patients would all want  
6 to go to the larger hospitals, where their bill was  
7 paid for them.

8 DR. VADEBONCOEUR: In this region here  
9 there are many small hospitals, about 15 to 18 beds,  
10 which are so functioning. Even since the introduction  
11 of the hospital plan, and it is a rather large figure,  
12 and many deliveries are made there, and there is no  
13 inspection, no consultation. I think this is a field  
14 which is of great concern to us to have at least a  
15 minimum of this security and the possibility of consulta-  
16 tion in these small hospitals which have 20 or 15 beds,  
17 small maternity wards, which we have here in Montreal.  
18 I think that the line has not been drawn between these  
19 hospitals that receive subsidies under the hospital plan  
20 and those who do not receive it, and this is a question  
21 of inspection and consultation and equipment, so that  
22 they can do deliveries decently according to the  
23 standards.

24 THE CHAIRMAN: Is the situation only in  
25 the city of Montreal?

26 DR. VADEBONCOEUR: In Montreal and in the  
27 surroundings of Montreal also, and in the province, in  
28 each town there is a maternity ward hospital. There are  
29 many small maternity wards that were founded by private  
30 persons. We don't know what the future will be in a  
year or so. At present the patients have a tendency  
to go to a large department.

large number of them are receiving funds from the hospital-  
are so doing. Otherwise the patients would all have  
to go to the Kaiser hospital, where their bill was

DR. WATSON: In this region here

there are many small hospitals, about 10 to 15 beds,  
which are so situated. Even since the construction  
of the hospital plan, and it is a rather large figure,  
and many deliveries are made there, and there is no  
inspection, no consultation. I think this is a field  
which is of great concern to us to have at least a  
minimum of this security and the possibility of communi-  
cation in these small hospitals which have 10 or 15 beds,  
small maternity wards, which we have here in Montana.  
I think that the line has not been drawn between these  
hospitals that need a supervisor under the hospital plan  
and those who do not receive it, and this is a decision  
of inspection and control, and I am not prepared, so that  
they can be delivered properly according to the  
standards.

DR. WATSON: Is the situation any in

the city of Montana?

DR. WATSON: In Montana; and in the

as you know of course also, and in the province, as  
soon for there are a number of small hospitals. There are  
many small maternity wards that were built up by private  
persons. We don't know what the future will be in  
view of it. At present the matter is in a condition  
of a large hospital.



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3 THE CHAIRMAN: Were these founded by  
4 doctors?

5 DR. VADEBONCOEUR: Some were founded by  
6 doctors, others by other people. We don't know where  
7 the funds come from in some places. We don't know what  
8 will happen in a year's time, with the hospital  
9 insurance. We know from our patients that they don't  
10 want to go to these small maternity wards so much.

11 THE CHAIRMAN: Does the selection not  
12 rest with the doctor?

13 DR. VADEBONCOEUR: There is a special  
14 situation here in obstetrics and gynaecology, that is that  
15 general practitioners do a lot of deliveries, and often  
16 they have a small maternity ward near their house, and  
17 the patient likes that. It gives a family atmosphere.  
18 They feel a certain sense of security in going there,  
19 and of course this is very often very deceptive. But  
20 what counts of course is the delivery room and easy  
21 consultation, the equipment and the possibilities and  
22 analyses and so on. We haven't checked this. Of course  
23 some patients like to go to a small house, these small  
24 private hospitals, because it is easier to go there,  
25 and they have often been there two or three times  
26 before, and they feel a certain attachment to that house  
27 and want to go back to it. That is the problem of  
28 course, the problem of knowing what happens and how  
29 consultation can be arranged.

30 DR. TWEEDIE: This problem is essentially  
one of Montreal. I was able to total up that of the  
deliveries in private hospitals, which number between





doctors?

DR. VANDERBILT: Some were founded by

doctors, others by other people. We don't know where the funds come from in some places. We don't know what will happen in a year's time, with the hospital insurance. We know from our patients that they don't want to go to these small maternity wards so much. THE CHAIRMAN: Does the speaker not

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situation here in obstetrics and gynecology, that is that general practitioners do a lot of deliveries, and often they have a small maternity ward near their house, and the patient likes that. It gives a family atmosphere. They feel a certain sense of security in going there, and of course this is very often very deceptive. But what counts of course is the delivery room and the consultation, the equipment and the possibilities of anesthesia and so on. We have only one room, in the case some patients like to go to a small house, these small private hospitals, because it is easier to go there, and they have often been there for three times before, and they feel a certain attachment to that house and want to go back to it. That is the position of course, the problem of going what a good and how consultation can be arranged.

DR. TOLSON: This speaker is essentially

one of Montreal. I was able to collect part of the deliveries in a private hospital, which number between



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4 13,500 and 15,000 a year in the Province of Quebec,  
5 as far as I can tell from those hospitals stating how  
6 much they do in the Canadian Hospital Directory,  
7 approximately 8,500 to 10,000 of this 13,000 to 15,000  
8 are delivered here in Montreal, or in the close  
9 proximity of Montreal.

10 Our complete theme on all aspects of  
11 these private hospitals is one of lack of information.  
12 We are ignorant of much of the organization of them.  
13 We don't know very much about how they are financed,  
14 and least of all do we know what standards of medical  
15 care exist there, except from individual patient  
16 experience which comes to us from time to time. We do  
17 hear that all is not well as far as practice is  
18 concerned.

19 THE CHAIRMAN: This is the first time  
20 that we have had this subject discussed. Now, in  
21 investigations we were making in New York of the  
22 hospital insurance programme there, we heard a lot about  
23 the same thing, and exactly the same type of complaint  
24 about the private hospital, but principally  
25 doctor-operated, and we didn't know of the situation  
26 until today, at least I didn't, that it was a major  
27 item in Canada, and particularly in the city of  
28 Montreal.

29 /PB/hm DR. TWEEDIE: They do over 10% of the  
30 deliveries in the Province of Quebec, and that is a  
significant number.

THE CHAIRMAN: Are you able to identify  
those who go to such hospitals by any, either some



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THE CANADIAN: This is the point that

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 about the private hospital, but particularly  
 doctor-operated, and we didn't know of the situation  
 until today, at least I don't, that it was a  
 item in Canada, and particularly in the city of  
 Montreal.

THE CANADIAN: They do cover 100 per cent

delivered in the Province of Quebec, and that is a  
 significant number.

THE CANADIAN: Are you able to identify

cases who go to such hospitals by now, either





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3 economic basis or some other form of identification?

4 Regionally we know it is Montreal and the surrounding area,  
5 but who is it that likes to go, I mean to say, is there  
6 any identification? You say some wish to pay their own  
7 way and pay it exclusively. That might be one reason.

8 DR. TWEEDIE: Dr. Lapointe, would you  
9 care to answer.

10 THE CHAIRMAN: Dr. Vadeboncoeur said  
11 that it was sentimental attachment.

12 DR. VADEBONCOEUR: Yes sir.

13 THE CHAIRMAN: What is the group that  
14 so chooses? When you have 10% of your total deliveries  
15 there must be some way of identifying those who choose  
16 to go that way.

17 DR. LAPOINTE: If I may, Mr. President,  
18 I would like to say there are a certain number of  
19 patients who have sentimental attachments and want to  
20 go to the small hospital. I think they don't represent  
21 the majority. I think in the small hospitals you don't  
22 have specialists but general practitioners who deliver  
23 there, about 90% are general practitioners. General  
24 practitioners don't go to large hospitals so much  
25 because they don't like to be supervised by specialists.

26 THE CHAIRMAN: Is it not the case they  
27 couldn't go to the larger hospitals?

28 DR. LAPOINTE: In certain hospitals  
29 they couldn't go there because they are not allowed to  
30 deliver in all the hospitals in Montreal. Each hospital  
has its own personnel, not only Montreal, but elsewhere.  
The doctor is attached to a hospital and he has the privilege



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but who is it that likes to go, I mean to say, is there  
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deliver in all the hospitals in Montreal. In a hospital  
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The doctor is attached to a hospital and he has the privilege



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4 of working in that hospital, but he doesn't have the  
5 privilege of working in all the hospitals in the city.  
6 It is the same elsewhere. Some physicians have access  
7 to a hospital and they do all their obstetrics there,  
8 all their patients go to that hospital. I think that  
9 the doctors who don't have access to the large hospitals,  
10 and don't go there, also because they don't want to  
11 be controlled, checked by specialists because all  
12 deliveries are controlled in such large hospitals. In  
13 the small private hospitals the physicians are not  
14 controlled at all. They do as they like and they  
15 prefer to work behind closed doors, an iron curtain,  
16 as it were, to do their obstetrical work. They tell  
17 their patients, I only take patients at such and such a  
18 hospital or I will treat you at some particular hospital  
19 so that patients who have confidence in their doctors  
20 go there with closed eyes, thinking it will be just as  
21 good in that hospital as in the large one. I don't  
22 think that the monetary arrangement comes into  
23 consideration so much then. That is how I look upon  
24 this question.

25 THE CHAIRMAN: If I may just pose this  
26 question. Is there a difference in the mortality rate,  
27 either infants or mothers, as between those hospitals  
28 and the general hospitals? I know you are saying there  
29 is a much higher mortality rate where the confinement  
30 is at home, but are you suggesting there is also a  
higher mortality rate, higher morbidity rate in these  
hospitals than in the general hospitals where there are  
rather higher standards?



of working in that hospital, but he doesn't have the

It is the same elsewhere, some physicians have access to a hospital and they to all their patients there,

All their patients go to that hospital. I think that the doctors who don't have access to the large hospitals, and don't go there, also because they don't want to

be controlled, checked by specialists because all deliveries are controlled in such large hospitals. In the small private hospitals the physicians are not controlled at all. They do as they like and they

prefer to work behind closed doors, as I said earlier, as it were, to do independent work. They tell their patients, I only take patients at night and send them to hospital or I will treat you at my particular hospital so that patients who have confidence in their doctors go there with closed eyes, thinking it will be just as good as that hospital as in the large one. I don't think that the temporary management comes into consideration so much then. That is how I look upon

THE QUESTION: I may have one more question. Is there a difference in the mortality rate, either among or between, as between large hospitals and the general hospitals? I know you are saying there is a much higher mortality rate where the confinement is at home, but are you suggesting there is also a higher mortality rate, higher mortality rate in these hospitals than in the general hospitals where there are



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4 DR. TWEEDIE: This problem is very  
5 difficult to establish because of a number of things.  
6 We can't sit here and say dogmatically that such is so,  
7 although we highly suspect that it is so.

8 THE CHAIRMAN: The figures would be  
9 available somewhere, would they not?

10 DR. TWEEDIE: Figures of such things  
11 as maternal mortality are available, because this is a  
12 legal matter. They have to report this by law.  
13 Practically no other figures are available. They report  
14 their maternal mortality because it is required by  
15 law. They report their perinatal mortality and that is  
16 about the extent of it. I understand that there are  
17 different methods of reporting lethal complications of  
18 pregnancy. For instance a woman dying of toxemia in  
19 pregnancy could be described on the death certificate  
20 as having died of a kidney failure and the pregnancy  
21 may not be mentioned. I understand this is one of the  
22 great weaknesses in the statistics in reference to this.  
23 Therefore, we don't know how many such case are reported  
24 referable to the primary cause of death without any  
25 reference made to the fact she was pregnant. We can't  
26 trust such statistics as we get on this matter. As far  
27 as morbidity is concerned we have no idea because these  
28 statistics from these hospitals are not published. That  
29 is my plea, we should know more about them.

30 THE CHAIRMAN: The recommendation you make  
is that a survey should be made of these hospitals as  
well as all hospitals?

DR. TWEEDIE: That is correct.







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4 DR. LAPOINTE: Mr. Chairman, the question  
5 you have raised concerning statistics, we did conduct  
6 a survey in all the hospitals in the province, but the  
7 small hospitals didn't reply. We asked information on  
8 mother mortality rates and infant mortality rates. But  
9 we know most of the mortality occurs in the large  
10 hospitals because patients are transferred to these  
11 large hospitals, very often the patients are transferred  
12 from the small hospitals to the large hospitals in the  
13 state of unconsciousness. The patients arrives to us  
14 almost half dead and sometimes it is a urinal complica-  
15 tion and they wait until there is no urination before  
16 transferring the patient to us, so the fact is that  
17 there are very few statistics available on their mortality  
18 because patients are very often transferred to the  
19 large hospital at the point of death. If we  
20 had statistics the statistics would be false or  
21 practically false. The mortality rates we studied in  
22 Quebec, most of these statistics come from large  
23 hospitals. Many of the patients that were received in  
24 large hospitals are transferred by train from smaller  
25 centers.

26 DR. MAUGHAN: We have no statistics  
27 investigating maternal death in this province. We would  
28 probably like to have a system similar to the system  
29 enforced in the Province of Ontario, but at the moment  
30 we have none. We do know that certain women's death  
certificates are signed as having died of anemia and  
only later in some small investigation will it come out  
that they were actually pregnant and died of post-partum



you have raised concerning statistics, we did conduct a survey in all the hospitals in the province, but the small hospitals didn't reply. We asked information of their mortality rates and infant mortality rates. We know most of the mortality occurs in the large hospitals because patients are transferred to these large hospitals, very often the patients are transferred from the small hospitals to the large hospitals in the state of infectious cases. The patients arrive to us almost half dead and sometimes it is a critical condition and they wait until there is no reaction before transferring the patient to us, so the fact is that there are very few statistics on small hospitals or their mortality rates. Patients are very often transferred to the large hospitals at the point of death. If we had statistics on the patients who are transferred to the large hospitals, the mortality rates would be raised. Indeed, most of these statistics come from large hospitals. Many of the patients that come received in large hospitals are transferred by train from smaller hospitals. We have no statistics investigating maternal death in this province. We would probably like to have a system similar to the system enforced in the Province of Ontario, but at the moment we have none. We do know that deaths are high and that the statistics are high as a result of the high mortality rate in the small hospitals. I do come out that they are a problem and that of course



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4 hemorrhage. In the experience of the mortality committee  
5 of our association we have experienced that sort of thing.  
6 However, to the question about the calibre of obstetrics  
7 that is done in the small hospitals we have throughout  
8 the Province of Quebec perinatal mortality, which is  
9 stillbirths and infants in their first week of life,  
10 has been standing around 33 per 1000. It is lower. It  
11 was up to 39 per 1000 a few years ago. It is 33 per  
12 1000. In our own clinic our perinatal mortality is  
13 17 per 1000. That I think is the answer to the question  
14 of how well the small hospitals and the home deliveries  
15 are performed their functions of getting good healthy young  
16 Canadians.

17 THE CHAIRMAN: Dr. Van Wart.

18 COMMISSIONER VAN WART: Dr. Tweedie, we  
19 all recognize that something has to be done to correct  
20 the present condition in smaller hospitals, but in the  
21 principle, I think when you state that inspection of  
22 these hospitals should be mandatory as essential  
23 qualifications for hospital benefit, I think as a  
24 principle you are going contrary to the principles that  
25 exist at this time. Hospital accreditation is only  
26 carried out on the invitation of the hospital, and second  
27 the province recognizes the hospital accreditation reports  
28 and they have no hospital accreditation boards of their  
29 own. Now, you are suggesting a mandatory inspection of  
30 the hospitals for civic purposes and that would mean  
the transference to the hospital plan, inspection of  
all hospitals in Canada, which is contrary to the  
principle which is invoked at the present time. It would





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14 per 1000. That I think is the answer to the question  
of how well the small hospitals and the home deliveries  
are performing their functions of getting good healthy young

DR. CHURMAN: Dr. Van Wert.

DR. VAN WERT: I am, Dr. Van Wert.

all to suggest that something has to be done to correct  
the present condition in smaller hospitals, but in the  
principles, I think when you state that inspection of  
these hospitals should be necessary as essential  
qualifications for hospital facilities, I think as a  
principle you are going contrary to the principles that  
we at this time, hospital people, have only  
worked out of the final vision of the hospital, and second  
the province needs the hospital facilities, without  
any more hospital facilities, as we are not  
own. Now, you are asking a very large question of  
the hospital for civil purposes and that would mean  
the responsibility to the hospital plan, inspection of  
all hospitals in Canada, which is contrary to the  
principles which is followed at the present time. It would



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3 seem to me that some other method of accomplishing this  
4 would be more in line with what is the practice in the  
5 accreditation inspection in the position of the hospital  
6 plans all over the country. The suggestion made by  
7 Dr. Maughan of provincial maternal statistics,  
8 availability of reports of that nature, might be a  
9 better approach than through mandatory inspections  
10 which you suggest. I want to know your reaction to that.

11 DR. MAUGHAN: Dr. Van Wart, we have the  
12 restaurants that serve the public that are inspected as to  
13 their cleanliness and the health of their employees and  
14 so on. It seems to me that hospitals by the same token  
15 should or must live up to minimum standards when they  
16 are looking after ill patients. Most particularly I  
17 think this is true when they are looking after the  
18 obstetrical patients where danger of infection and so  
19 on, as you well know, is much more likely.

18 THE CHAIRMAN: The infant?

19 DR. MAUGHAN: And the infant.

20 THE CHAIRMAN: Who is essentially a  
21 ward of the State, to whom the State has a special duty  
22 in law?

23 DR. MAUGHAN: That is right, it just  
24 seems to me such organizations as these small hospitals  
25 that will not take accreditation should not be allowed  
26 to be in business. Every hospital should be accredited  
27 on a minimum standard. The standards of the Commission  
28 on Accreditation vary from large hospitals to small  
29 hospitals. They set up these minimum standards. It is  
30 my belief that all hospitals should meet these minimum







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standards. The exact method of achieving this end I am not quite sure, but quite possibly as in so many instances the dangling of bonuses or grants to the hospitals through the Hospitals Act might be an effective method of so doing.

DR. TWEEDIE: I, on Wednesday, attended a symposium, a panel symposium at the Province of Quebec Hospital Association meeting on hospital standards of care, and this very point came up. The president of the Quebec College of Physicians and Surgeons practically offered the services of that group as one that might survey the small hospitals under 25 beds, or even over 25 beds in the province who don't voluntarily seek hospital accreditation. I might say that the representative of the hospital council of accreditation breathed a sigh of relief and said he thought that would be a very good idea. I was pleased to hear that a legal body in this province has indicated they would undertake such surveillance. We think it is a very, very important thing, whether it is done in the manner in which we suggest or not I think is of secondary importance, as long as it is done.

THE CHAIRMAN: Dr. Tweedie, having listened to what was said this afternoon that the principal culprits in the deal are your doctors, do you think a doctor organization is the one to police it?

DR. TWEEDIE: I think it might well be the one to police it.

THE CHAIRMAN: Probably should be the one.





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4 DR. TWEEDIE: I agree entirely that the  
5 doctors initially should police the medical services  
6 and medical care standards just as far as it is possible,  
7 if they fail, I think somebody else will have to do the  
8 job. I think the medical profession should do it for  
9 themselves.

10 THE CHAIRMAN: I don't mean this  
11 offensively, why has it not been done?

12 DR. TWEEDIE: This question is difficult  
13 to answer. I would only say it should have been done  
14 and it certainly ought to be done now. The reason given  
15 on Wednesday at this panel that I heard, was that there  
16 are legal implications in the present set-up insofar as  
17 any organization presently instituted may not have the  
18 legal right to do this.

19 THE CHAIRMAN: Any hospital, no doubt  
20 any private institution could shut the doors and say  
21 stay out?

22 DR. VADEBONCOEUR: That is right.

23 DR. TWEEDIE: That is the essence of  
24 why it hasn't been done to the present time, but we are  
25 here to say it should be done and done by the medical  
26 profession, if possible.

27 THE CHAIRMAN: Insofar as hospitals  
28 which we see -- which are qualified to receive payments  
29 under the Hospitalization Act, I understand within the  
30 last several weeks as many as 15 have been struck off  
the eligible list so somebody must by interesting them-  
selves in this matter.

DR. TWEEDIE: I have heard mention. I





MR. TWISS: I agree entirely that the

and medical care standards just as far as it is possible

if they fail, I think somebody else will have to do the

job. I think the medical profession should do it for

themselves.

THE CHAIRMAN: I don't mean this

offensively, why has it not been done?

MR. TWISS: This question is difficult

to answer. I would only say it should have been done

and it certainly ought to be done now. The reason given

on Wednesday at this panel when I heard, was that there

are legal implications in the present self-insular as

any organization possibly instituted may not have the

legal right to do this.

THE CHAIRMAN: Any hospital, no doubt.

any private institution could shut the doors and say

away with it.

MR. VANDERBILT: That is right.

MR. TWISS: That is the essence of

why it hasn't been done to the present time, but we are

here to say it should be done and done by the medical

profession, if possible.

THE CHAIRMAN: I agree as hospitals

which are - which are qualified to receive payments

under the Hospitalization Act, I understand within the

last several weeks as many as 15 have been struck off

the eligible list so somebody must be investigating them.

It is an interesting matter.

MR. TWISS: I have heard nothing.



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4 can't say on what basis they were struck off. Perhaps  
5 some of my confreres can, but I would doubt it was a  
6 result of a survey of medical care standards. I really  
7 don't know.

8 THE CHAIRMAN: Dr. Baltzan.

9 COMMISSIONER BALTAN: The hour is getting  
10 late, but there are a few things I must get clear in  
11 my own mind and in my own conscience. I refer again  
12 to what has been mentioned before. I will read it  
13 specifically on page 3. I will put it very briefly:  
14 These private hospitals are staffed by doctors of  
15 assorted qualifications and backgrounds, who generally  
16 choose to remain in voluntary detachment from organized  
17 medicine and who tend to ignore the various forms of  
18 self-imposed discipline et cetera. My question to you  
19 gentlemen is where does your College of Physicians and  
20 Surgeons come in on this?

21 DR. TWEEDIE: This is a question that  
22 I think should be asked of the College of Physicians  
23 and Surgeons. I certainly would not take it upon myself  
24 to answer a direct question which is really to be  
25 answered by them.

26 COMMISSIONER BALTZAN: I do not want  
27 to embarrass you. Had I had this brought to my attention  
28 this morning I would have placed that question and have  
29 had it answered. I will just leave it.

30 Just one other thing, this situation of  
privately-owned hospitals by doctors and, I understand,  
some are owned by business organizations, certainly in  
the United States they are. My question is, who promotes

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some of my colleagues can, but I would doubt it was a  
result of a survey of medical care standards. I really  
don't know.

COMMISSIONER BARTON: The room is getting

late, but there are a few things I must get clear in  
my own mind and in my own conscience. I refer again  
to what has been mentioned before. I will read it  
specifically on page 8. I will put it very briefly:  
These private hospitals are staffed by doctors of  
assorted qualifications and backgrounds, who generally  
choose to remain in voluntary detachment from organized  
medicine and who tend to ignore the various forms of  
self-imposed discipline of society. My question to you  
gentlemen is what does your College of Physicians and  
Surgeons have to say on this?

DR. TAYLOR: This is a question that

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and Surgeons. I certainly would not take it upon myself  
to answer a direct question which is really to be  
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this morning I would have placed that question and have  
had it answered. I will just leave it.  
Just one other thing, this situation of  
privately-owned hospitals by doctors and, I understand,  
some are owned by business organizations, particularly in  
the United States, they are, in question, who should





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3 these organizations and attracts patients? Is there  
4 any active advertising scheme? What puts it into  
5 existence, what makes them run?

6 DR. TWEEDIE: In some instances I believe  
7 there is advertising. If one reads the yellow section  
8 of the telephone book it is not too hard to see it  
9 right there. I do know to what extent they advertise  
10 publicly in other ways. Again, I would have to say our  
11 theme in this matter is one of ignorance of what goes  
12 on in all phases of the work of these hospitals.

13 COMMISSIONER BALTZAN: Speaking of  
14 small hospitals generally and places that are not  
15 accredited that serve communities, these small hospitals,  
16 is it poor hospital provisions, delivery room facilities,  
17 is that one of the causes for their poor results or  
18 would you go so far as to say that there are poor  
19 obstetrical practices?

20 DR. TWEEDIE: I would answer that by  
21 saying that I think there are a number of factors. I  
22 think they are poorly equipped, I think they are probably  
23 overcrowded but I cannot speak from personal experience.  
24 Generally speaking they are staffed by practitioners  
25 who have no special qualifications in the practice of  
26 obstetrics. Not that that is a sin but I think the  
27 thing is that they rarely request consultation. I doubt  
28 if any of my colleagues here have consulted in private  
29 hospitals -- I do not know. We hear from the results  
30 of the work that is carried out mainly through individual  
patient experiences. We take a history and get a story  
and sometimes the story is quite illuminating. There may





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4 other factors but I have to say that we know so little  
5 about them, that is why we are recommending something  
6 be found out.

7 COMMISSIONER BALTZAN: There is also  
8 a problem with a doctor's conscience in connection with  
9 that?

10 DR. TWEEDIE: I would think so.

11 COMMISSIONER BALTZAN: We might as well  
12 say what we think and know.

13 DR. TWEEDIE: Or perhaps lack of  
14 conscience.

15 COMMISSIONER BALTZAN: Gentlemen, would  
16 open hospitals, that is, opening up the hospitals and  
17 making it possible for physicians to obtain staff  
18 appointments not tend to ameliorate this condition which  
19 prompts doctors and patients to go to lesser types of  
20 institutions such as we have been speaking about?

21 DR. MAUGHAN: I think possibly, Dr.  
22 Baltzan, in part at least the answer is "yes". I am  
23 chief of a teaching hospital and yet a hospital that is  
24 not completely closed to specialists. It is a so-called  
25 courtesy staff who have obstetrical privileges and these  
26 non-qualified specialist obstetricians are allowed to  
27 do normal obstetrics in my hospital. I might say they  
28 were one of my greatest headaches. They have wakened me  
29 in the middle of the night much more than many of my own  
30 specialist colleagues in the hospital. Very often they  
do not recognize the problems even when the problems  
stare them in the face and it is only my house staff that  
finds the troubles and bring them to my attention so we







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4 can end up with the relatively happy result. This is  
5 an awfully difficult problem; if a man is going to help  
6 them through their difficulties they have to have  
7 access to good obstetrical hospitals.

8 COMMISSIONER BALTZAN: Then could one  
9 assume that they are not sufficiently trained, the  
10 under-graduates in the immediate internship year to be  
11 called upon to give that service to women because nobody  
12 knows when you are going to run into an abnormal  
13 situation?

14 DR. MAUGHAN: Well, nowhere in medicine,  
15 as you know, would you run into emergency more rapidly  
16 then in obstetrics and it is a matter of minutes in  
17 many instances. I would believe these people are not  
18 well enough trained or else they have forgotten their  
19 training.

20 COMMISSIONER BALTZAN: Or the teachers  
21 have forgotten to give them enough training. One other  
22 thing; on page 6:

23 "Our specialty to this society should

24 "support a school to promote ..... in

25 "the future."

26 This is not contained as a recommendation or it may have  
27 been but my thought on the matter is, and the question  
28 is, is this not actually an internal medical organiza-  
29 tional matter rather than passing this to somebody else?

30 DR. TWEEDIE: It is indeed an internal  
medical matter. This is our first recommendation and it  
is has already been taken up with the appropriate  
medical bodies. We perhaps might have left this out of



can and no with the relatively heavy results. And it is  
an actually different problem, it's a matter of being  
then through their difficulties they have to have  
access to good educational facilities.

COLONEL JOHN BARTON: Then could one

assume that they are not sufficiently trained, the  
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DR. WATMAN: Well, nowhere in medicine,

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than in obstetrics and it is a matter of minutes in  
many instances. I would believe those people are not  
well enough trained to know they have forgotten their

COLONEL JOHN BARTON: On the other

have to learn to learn from each other. One other  
thing on page 10

"One specialty is rising rapidly while  
"another is subject to periods of... it

"the same."

It is not contained as a recommendation on it may have  
been put on thought on the matter is, and the question  
is, as this not exactly an internal medical organization  
internal rather than having to do with somebody else?

Medical society. This is one first professional and it  
is has already been taken up by the specialists  
medical society. It perhaps might have left this out of





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3 the brief, we wanted to, however, indicate that in this  
4 province we do have a little bit of a special problem  
5 because we have these three categories of specialists  
6 in obstetrics, gynaecologists and the combined obstetricians  
7 and we present arguments and reasons why they might  
8 well be welded into one specialty.

9 COMMISSIONER BALTZAN: So it is a matter,  
10 I expect, which can be arranged on your own?

11 DR. TWEEDIE: Yes.

12 COMMISSIONER BALTZAN: Page 8 I would  
13 refer to the first three lines of the second paragraph:

14 "Until recently there has been surprising

15 "lack of liaison and exchange of ideas

16 "between the health services of the

17 "Provincial Government and the practising

18 "medical profession."

19 My question is simple but the answer might not be: What  
20 is the difficulty in coming to terms with departments  
21 of government?

22 DR. TWEEDIE: I would say that the fault  
23 probably is not with any one branch, to be fair, but  
24 on the other hand there is no reason why whenever a  
25 problem does arise the direction of transportation should  
26 always be in the same direction. In other words, one  
27 should not always have to go to the government to consult  
28 on problems which are of combined responsibility. I  
29 refer to one or two things as an example, for instance,  
30 the government officially collects statistics on mortality  
rates and so forth. I have visited that department and  
I got the impression that these statistics are collected



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the government officially collects statistics on mortality  
rates and so forth. I have visited that department and  
I got the impression that the statisticians are collecting



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3 and reported and filed and I do not think too much  
4 account is taken of them. We are concerned about some  
5 of our statistics referable to maternal and perinatal  
6 mortality in Quebec. We hope to get much more liaison  
7 with the government and we will promote it from our  
8 side to the best of our ability in the future perhaps  
9 without making too many complications. I would say  
10 only recently it was rather difficult to approach the  
11 departments of government with any sense of equality.

12 COMMISSIONER BALTZAN: In these matters  
13 of individuals dealing with the department concerned,  
14 these are usually channelled through doctors of public  
15 health who are in charge of these departments and there  
16 should not be too much difficulty in one medical man  
understanding another medical man.

17 DR. TWEEDIE: I do not think it is so  
18 much a matter of the medical men understanding one  
19 another, I think our efforts have certainly not been  
20 co-ordinated. I would not say the fault is all in one  
21 direction by any means. Stimulated by the preparation  
22 of this brief and the work we put into it I think we are  
23 now much better prepared to make a positive approach  
24 to the government as a representative body and this  
25 is what we intend to do, to see what we can do about  
these outstanding problems.

26 DR. MAUGHAN: Our local chairman of the  
27 internal welfare committee of the Canadian Medical  
28 Association has been functioning here in the province  
29 for the last six or eight years and it is only in the  
30 last two or three years that he has been able to get from







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4 the province any true statistics on maternal mortality  
5 and that is because they just were kept in the  
6 provincial archives. As well as that, we have not had  
7 any success in setting up a system such as I referred  
8 to earlier in Ontario where the medical profession  
9 can investigate maternal deaths. As they are done there  
10 medical men are actually deputies of the Department of  
11 Health so they have the associate of the Department  
12 of Health go and investigate.

13 COMMISSIONER BALTZAN: In conclusion  
14 let me say I compliment you for being so frank, forth-  
15 right and critical. Will you just answer this, please,  
16 if you can. On page 14, four lines from the bottom  
17 you say:

18 "... a significant number of hospitals  
19 "of several hundred beds where there  
20 "seems to be resistance to specialist  
21 "intrusion on the part of those in  
22 "charge."

23 What do you mean by that?

24 DR. TWEEDIE: This statement is, I  
25 think, based in fact. We have stated in our brief there  
26 are hospitals of considerable size in this province,  
27 100, 200, 300 beds, some of them should have either  
28 no specialists in obstetrics and gynaecology or one  
29 or two. There are instances where young well qualified  
30 men completely certified have applied to such hospitals  
and not received favourable consideration on their  
application to get on staff. There are other incidents  
where men are on staff, they are qualified to do

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provincial archives. As well as that, we have not had  
any success in setting up a system such as I referred  
to earlier in Ontario where the medical profession  
investigate maternal deaths. As they are done there  
medical men are actually deputized of the Department of  
Health so they have the associates of the Department  
of health go and investigate.

COMMISSIONER BARTON: In conclusion

let me say I commend you for being so frank, forth-  
right and cordial. Will you just answer this, please,  
if you can. On page 14, four lines from the bottom

"..... a significant number of hospitals  
"of several hundred beds where there  
seems to be no chance to specialist  
attention on the part of those in

"charge."

What do you mean by that?

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think, based in fact. We have stated in our brief that  
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where men are on staff, they are qualified to do





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4 obstetrics or gynaecology and they are not permitted to  
5 do so or they may be permitted to do so only in a  
6 restricted or confined sense. These are things that  
7 spring to my mind and perhaps Dr. Lapointe can add to  
8 that.

9 DR. LAPOINTE: I know of some hospitals  
10 of 300 or 500 beds or so controlled by surgeons and the  
11 surgeons who control the hospital are not interested  
12 in gynaecologists because he has a nice hospitals and  
13 he is not at all interested in having gynaecologists  
14 come into his picture. It is the same thing in many  
15 towns outside of Montreal. As I mentioned, in Montreal  
16 itself there are hospitals, even city hospitals which  
17 are not looking for a gynaecologist because the  
18 gynaecology is controlled by the general surgeon in  
19 hospital. As Dr. Tweedie said, there are excellent  
20 people in all these hospitals who applied not only to  
21 join the staff but also to have consultations and they  
22 are refused even as consultants, they do not even have  
23 consulting gynaecologists or obstetricians in hospitals.

24 COMMISSIONER BALTZAN: That, to finish  
25 up, is actually a matter of soft responsibility, soft  
26 organization and soft discipline.

27 DR. LAPOINTE: Quite true.

28 COMMISSIONER FIRESTONE: On page 13 in  
29 the second paragraph you say, and I quote:

30 "For that critical segment of public  
"opinion which constantly seeks a  
"platform or a whipping post, the doctors  
"relative income status lends itself to



obstetrics or gynecology and they are not permitted to do so or they may be permitted to do so only in a restricted or confined sense. These are things that spring to my mind and perhaps Dr. Lacombe can add to

DR. LACOMBE: I know of some hospitals of 300 or 500 beds or so controlled by surgeons and the surgeons who control the hospital are not interested in gynecologists because he has a nice hospital and he is not at all interested in having gynecologists come into his hospital. It is the same thing in many towns outside of Montreal. As I mentioned, in Montreal itself there are hospitals, even city hospitals which are not looking for a gynecologist because the gynecology is controlled by the general surgeon in hospital. As Dr. Tweedie said, there are excellent people in all these hospitals who applied not only to join the staff but also to have consultations and they are refused even as consultants, they do not even have consulting gynecologists or obstetricians in hospitals.

COMMISSIONER: What, to finish up, is actually a matter of self responsibility, self organization and self discipline.

COMMISSIONER: On page 13 in the second paragraph you say, and I quote:

"For that and all sort of things

"which which constantly comes a

"disturbance or a whipping post, the doctor

"relative income across lands itself to



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3 "charges of excessive professional fees  
4 "and opulence, but it can be easily  
5 "shown that in the last 25 years the  
6 "average increase in such fees have been  
7 "proportionately much less than increase  
8 "in cost of hospitalization, of drugs,  
9 "of wage levels and of living in general."

10 Does this statement apply to conditions  
11 in the Province of Quebec or to Canada as a whole?

12 DR. TWEEDIE: This statement applies  
13 in a narrow sense not only to the Province of Quebec  
14 but I am really speaking of our specialty in the Province  
15 of Quebec. I am not making a particular generalization,  
16 I am making a statement referable to our specialty,  
17 because I feel it is in that group of which I have  
18 any information or for which I can speak with any  
19 authority at all.

20 COMMISSIONER FIRESTONE: You say it  
21 could easily be shown that this is the case; would it  
22 be possible for your association in substantiating the  
23 point you have made in this submission to us to let  
24 us have in writing a statement providing us with the  
25 facts on which the statement is based and could that  
26 be sent to the secretary of this Commission?

27 DR. TWEEDIE: I would be pleased to do  
28 that, sir.

29 COMMISSIONER FIRESTONE: Thank you,  
30 Dr. Tweedie. Now, one more question; on page 15 in  
your recommendation 7 (d) you refer to the assessment  
of statistics relative to maternal and perinatal  
mortality; are you referring to statistics collected by







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the Provincial Government or the Federal Government?

AG/hm DR. TWEEDIE: I am referring to statistics collected by the Provincial Government, and my reference is to the statement made a few minutes ago, that I have the feeling that they are collected, reported, and filed, and that very little effort is made to interpret them, or to get any meaning out of them, or to use them as a guide for next year's programme, and so forth.

COMMISSIONER FIRESTONE: I take it you are interested in obtaining these statistics, and also an assessment of such statistics, as an association?

DR. TWEEDIE: Yes we are.

COMMISSIONER FIRESTONE: Well sir, are you familiar that the Dominion Bureau of Statistics has been collecting figures in this field, and that the Department of Health and Welfare has been undertaking analyses of health statistics from time to time?

DR. TWEEDIE: I am familiar with that. As a matter of fact I have used these sources to gather some background information for this presentation, but they can supply us with certain statistics, but I would like to see the statistics interpreted by a group or groups such as the appropriate government department and our Association together, so that we could try to, from our interpretations, get some lead as to where we might best apply our energies in the future. This is the concept that is within that statement.

COMMISSIONER FIRESTONE: Have you been able to obtain the statistics which you require from the







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3 Dominion Bureau of Statistics, in your specialized field?

4 DR. TWEEDIE: Yes I have.

5 COMMISSIONER FIRESTONE: Therefore you  
6 have no suggestions to make as to how the Federal  
7 Bureau of Statistics could be improved so as to throw  
8 more light in your own area?

9 DR. TWEEDIE: I had not thought about  
10 this point. I would think that they might have quite  
11 a bit to offer in respect to analyzing statistics, and  
12 if their advice could be sought I think it would be  
valuable.

13 COMMISSIONER FIRESTONE: Are you  
14 familiar, sir, that the Bureau of Statistics is a  
15 central statistical collection agency, with the analysis  
16 being pretty much left in the hands of the operating  
17 departments in this case the Department of National  
18 Health and Welfare? They have an Economics and Research  
19 branch, which provides that type of analysis. Have  
20 you approached that Department, or that particular branch  
21 of that department, to undertake the kind of analysis  
that you have suggested would be useful?

22 DR. TWEEDIE: I personally have not  
23 approached them. I would ask Dr. Maughan if he has  
24 consulted them in this regard, because he deals with  
25 them more often than I do?

26 COMMISSIONER FIRESTONE: Well, would  
27 you not feel that if such facilities were available that  
28 use could be made of them so that you would have a basis  
29 of discussion when you wished to discuss some problems  
30 with the appropriate provincial departments of health?





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3 DR. TWEEDIE: I think that is a very  
4 good suggestion.

5 COMMISSIONER FIRESTONE: And are you  
6 also familiar with the fact that the Quebec Bureau of  
7 Statistics has recently been reorganized, and now provides  
8 a substantial statistical service to the province.  
9 Would you not feel that your Association could not  
10 perhaps get in touch with this new bureau and see what  
11 work they can do for you, now that they have the  
12 organization to do it?

13 DR. TWEEDIE: Yes, I think that again  
14 is a good suggestion. I think we should not stop at  
15 analyzing statistics. We should use those as an excuse  
16 to get together to find out in what ways we could work  
17 with the government.

18 COMMISSIONER FIRESTONE: You are quite  
19 right sir that the whole purpose of the collection of  
20 statistics is to provide you with the tools to formulate  
21 intelligent decisions, and help the government to formu-  
22 late intelligent policies. I take it from your answer  
23 that this is what you are planning to do?

24 DR. TWEEDIE: Yes sir.

25 THE CHAIRMAN: Thank you very much Dr.  
26 Tweedie and gentlemen. As you can appreciate from the  
27 nature of the questions, your presentation here has been  
28 very interesting, and in a sense relatively different  
29 from many other submissions we have heard, and it has  
30 introduced some new features which will receive very  
serious consideration, and your brief, as well as the  
record of what has transpired here this afternoon,







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4 will go to the medical survey project people as well,  
5 to the medical education project under Dr. MacFarland,  
6 and with whom Dr. Roger Dufresne of Montreal here is  
7 associated, so the whole record will be in their hands  
8 as well.

9 DR. TWEEDIE: May I say as obstetricians  
10 we like to give birth to new ideas and fresh approaches,  
11 and may I, on behalf of my colleagues, thank the  
12 Commissioner for your thoughtful consideration of our  
13 points of view.

14 THE CHAIRMAN: We adjourn until 9:30  
15 Monday morning.

16 ---ADJOURNMENT.  
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